# PUTTING KIDS FIRST: ADDRESSING COVID-19'S IMPACTS ON CHILDREN

## HYBRID HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE

COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

SEPTEMBER 22, 2021

Serial No. 117-48



Published for the use of the Committee on Energy and Commerce govinfo.gov/committee/house-energy energycommerce.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE

52--961~PDF WASHINGTON: 2023

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## C O N T E N T S

	Page
Hon. Diana DeGette, a Representative in Congress from the State of Colorado, opening statement Prepared statement Hon. H. Morgan Griffith, a Representative in Congress from the Commonwealth of Virginia, opening statement Prepared statement Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement Prepared statement Hon. Cathy McMorris Rodgers, a Representative in Congress from the State of Washington, opening statement Prepared statement Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, prepared statement	2 4 5 6 8 9 10 12 119
Witnesses	
Lee Beers, M.D., President, American Academy of Pediatrics Prepared statement Answers to submitted questions  Margaret G. Rush, M.D., President, Monroe Carell Jr. Children's Hospital at Vanderbilt Prepared statement Answers to submitted questions  Arthur C. Evans, Jr., Ph.D., Chief Executive Officer, American Psychological Association Prepared statement Answers to submitted questions  Kelly Danielpour, Founder, VaxTeen Prepared statement Tracy Beth Hoeg, M.D., Ph.D., Epidemiologist and Public Health Expert, Private Practice Physician Prepared statement	14 17 148 26 28 153 47 49 156 66 68 71
SUBMITTED MATERIAL	
Article of Sept. 14, 2021, "Facebook Knows Instagram Is Toxic for Teen Girls, Company Documents Show," by Georgia Wells, Jeff Horwitz, and Deena Seetharaman, Wall Street Journal submitted by Mr. Burgess	121

## PUTTING KIDS FIRST: ADDRESSING COVID-19'S IMPACTS ON CHILDREN

## WEDNESDAY, SEPTEMBER 22, 2021

House of Representatives. SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, COMMITTEE ON ENERGY AND COMMERCE, Washington, DC.

The subcommittee met, pursuant to call, at 10:30 a.m., in the John D. Dingell Room 2123, Rayburn House Office Building, and remotely via Cisco Webex online video conferencing, Hon. Diana

DeGette (chair of the subcommittee) presiding.

Members present: Representatives DeGette, Kuster, Rice, Schakowsky, Tonko, Ruiz, Peters, Schrier, Trahan, O'Halleran, Pallone (ex officio), Griffith (subcommittee ranking member), Burgess, McKinley, Palmer, Dunn, Joyce, and Rodgers (ex officio).

Also present: Representatives McNerney, Bilirakis, and Carter.

Staff present: Jesseca Boyer, Professional Staff Member; Austin Flack, Policy Analyst; Waverly Gordon, Deputy Staff Director and General Counsel; Tiffany Guarascio, Staff Director; Perry Hamilton, Clerk; Fabrizio Herrera, Staff Assistant; Zach Kahan, Deputy Director, Outreach and Member Service; Chris Knauer, Oversight Staff Director; Mackenzie Kuhl, Digital Assistant; Will McAuliffe, Counsel; Kaitlyn Peel, Digital Director; Chloe Rodriguez, Clerk; Andrew Souvall, Director of Communications, Outreach, and Member Services; C.J. Young, Deputy Communications Director; Sarah Burke, Minority Deputy Staff Director; Diane Cutler, Minority Detailee, Oversight and Investigations; Theresa Gambo, Minority Financial and Office Administrator; Marissa Gervasi, Minority Counsel Oversight and Investigations; Prittensy Hovers, Minority Counsel, Oversight and Investigations; Brittany Havens, Minority Professional Staff Member, Oversight and Investigations; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel, Oversight and Investigations Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; and Alan Slobodin, Minority Chief Investigative Counsel, Oversight and Investigations.

Ms. DEGETTE. The Subcommittee on Oversight and Investiga-

tions hearing will now come to order.

Today, the committee is holding a hearing entitled "Putting Kids

First: Addressing COVID-19's Impact on Children."

Today's hearing will explore the impacts of the coronavirus disease of 2019 pandemic on children and adolescents in the United States.

Due to the COVID-19 public health emergency, Members can participate in today's hearing either in person or remotely via online video conferencing.

Members who are not vaccinated and participating in person must wear a mask and be socially distanced. Members may remove their mask when they are under recognition and speaking from a

Staff and press who are not vaccinated and present in the committee room must wear a mask at all times and be socially distanced.

For Members who are participating remotely, your microphones will be set on mute for the purpose of eliminating inadvertent background noise. Members participating remotely will need to unmute your microphone each time you wish to speak.

Please note, once you unmute your microphone, anything that is said in Webex will be heard over the loudspeakers in the committee room and subject to be heard by the livestream and C-SPAN, as everybody on this committee learned during our marathon markup last week.

Because Members are participating from different locations at today's hearing, all recognition of Members, such as for questions,

will be in the order of subcommittee seniority.

If, at any time during the hearing, I'm unable to chair the hearing, the vice chair of the subcommittee, Mr. Peters—thank you for being here, Mr. Peters, I always appreciate it—will serve as chair until I'm able to return.

Documents for the record can be sent to Austin Flack at the email address that we have provided to staff. All documents will be entered into the record at the conclusion of the hearing.

And the Chair will now recognize herself for the purposes of an opening statement.

## OPENING STATEMENT OF HON. DIANA DEGETTE. A REP-RESENTATIVE IN CONGRESS FROM THE STATE OF COLO-RADO

Today, the subcommittee continues to focus on its top priority for this year: aggressively exploring how to bring the COVID-19 pandemic to an end. To date, we've conducted extensive oversight and numerous hearings on critical issues relating to controlling the virus. From the on-ground experiences of State leaders to vaccine development, distribution, and uptake. Curbing COVID-19 has been and, unfortunately, still remains this subcommittee's top priority until we bring the pandemic to an end.

Today's topic is central to the concerns of families across the country: how the pandemic affects our children and how to continue to ensure their health and well-being. As millions of students start the new school year, patients are facing agonizing decisions about in-person learning and childcare. Families across the country are balancing the risks and challenges of keeping their children safe, while striving to support their overall developmental and educational growth. Experts agree the best place for children is in the classroom—but only if steps are taken to make schools a safe place.

The goal we all share across this dais is keeping kids safe, a goal that has been threatened throughout the COVID-19 pandemic.

While children have been spared the same rates of severe symptoms or death as adults from the virus, we know that they are far from unscathed. Nearly 500 children have died due to COVID-19 in the United States, and another 5,000 children continue to suffer from a rare but serious inflammatory condition known as MIS-C.

And although research is ongoing, we don't know the long-term impacts COVID-19 infection has on children and adolescents, but, unfortunately, we do know that, just as among adults, Black and Hispanic youth face disproportionate impacts of COVID-19.

We also know that vaccines remain the most effective tool to fight the virus. A vaccine is currently available for adolescents 12 and older, but, unfortunately, only less than 42 percent of the

younger teens are fully vaccinated.

For kids under 12, we are all anxious for the FDA to authorize a safe and effective COVID-19 vaccine. Frankly, that approval cannot come soon enough. There's recent cause to be optimistic because the trial results for 5-to-11-year-old children released by Pfizer early this week appear to indicate that the vaccine is safe and effective for children.

Pfizer will reportedly submit and request Emergency Use Authorization for this vaccine in just a week or two, with the request

for children under 5 to follow in, later in this fall.

We will be counting the days, but it's important to underscore that FDA's process to assure the safety of vaccine for our children is essential to building the trust of American families.

In the meantime, ensuring people who are eligible get vaccinated is a vital step towards protecting children. Yet, while 65 percent of adults 18 and older are fully vaccinated across the country, that rate is still too low, and it dips further in some communities.

I was in a community in western Colorado this weekend where only 46 percent of adults were vaccinated. That's just unacceptable, and it leads to the continuing spread of the Delta variant around

the country.

So while we wait for vaccines for younger children, there's other things we can do to help reduce the risk of COVID-19. For example, just as using car seats and seatbelts are easy ways to help protect our children while in a car, we know that simple acts like wearing masks and maintaining physical distance while outdoors can minimize risk to children. We need to encourage those practices as much as possible.

However, contracting the virus isn't the only way our children's lives have been affected by the pandemic. Risks of exposure to COVID-19 last year led many parents to forego their children's visit to the doctor, leading to nearly 12 million fewer routine immunizations. And at the same time, other respiratory infections have surged or waned at atypical times, placing uncertainty and capac-

ity challenges on children's hospitals.

Also, the pandemic has had severe consequences on the mental health of America's youth. Even prior to the pandemic, adolescents in the U.S. experienced an epidemic of poor mental health, with increasing rates of stress, anxiety, depression, and suicidal thoughts and attempts.

All of these things are things we need to work on, and so that's why today we're focusing on young people. I'm very happy that we have a young person to share her perspective today, because we all want what is best for our children. We want to keep our kids healthy and safe.

United by that common purpose, we must work together to make sure we reduce the risk our children face and to do everything within our power to protect their health and well-being.

We all want an end to COVID-19 in our classrooms and in our communities, and I will work with the ranking member to make sure that's exactly what we do.

[The prepared statement of Ms. DeGette follows:]

## PREPARED STATEMENT OF HON. DIANA DEGETTE

Today, the Subcommittee continues to focus on its top priority: aggressively exploring how to bring the COVID-19 pandemic to an end.

To date, we have conducted extensive oversight and numerous hearings on critical issues related to controlling the virus-from on-the-ground experiences of state lead-

ers, to vaccine development, distribution, and uptake.

Curbing COVID-19 has been, and will remain, this Subcommittee's top priority until we bring this pandemic to an end.

Today's topic is central to the concerns of families across the country: how the pandemic affects our children and how to ensure their health and wellbeing.

As millions of students start the new school year, parents are facing agonizing de-

cisions about in-person learning and childcare.

Families across the country are balancing the risks and challenges of keeping their children safe while striving to support their overall developmental and educational growth.

Experts agree that the best place for children is in the classroom—but only if steps are taken to make schools a safe place.

The goal we all share across this dais is keeping kids safe—a goal that has been threatened throughout the COVID-19 pandemic.

While children have been spared the same rates of severe symptoms or death as adults from the virus, we know they are far from unscathed.

Nearly 500 children have died due to COVID-19 in the United States and another 5,000 children continue to suffer from a rare but serious inflammatory condition known as MIS 09C.

And, although research is ongoing, we do not yet know the long-term impacts of COVID-19 infection on children and adolescents.

But we do know that—just as it is among adults—Black and Hispanic youth face disproportionate impacts of COVID-19.

We also know that vaccines remain the most effective tool to fight the virus. A vaccine is currently available for adolescents 12 and older, yet fewer than 42 percent of these younger teens are fully vaccinated.

For kids under 12, we are all anxious for FDA to authorize a safe and effective COVID-19 vaccine. That approval cannot come soon enough. Fortunately, there is recent cause to be optimistic. The trial results for five- to 11-year old children released by Pfizer earlier this week appear to indicate its vaccine is safe and effective for children

Pfizer will reportedly submit and request Emergency Use Authorization for the use of its vaccine in this age-group in just a couple weeks, with its request for children under five to follow in November.

We will be counting the days, but it is important to underscore that FDA's process to assess the safety of the vaccine for our children is essential to building the trust of American families.

In the meantime, ensuring that those who are eligible get vaccinated is a vital step toward protecting children. Yet, while 65 percent of adults 18 and older are fully vaccinated across the country, that rate is still too low and dips even lower in many communities.

While we wait for vaccines for younger children, there are other concrete actions we can take to help reduce the risk of COVID-19 to kids.

For example, just as using car seats and seat belts are easy ways to help protect our children while in a car, we know that simple acts, such as wearing masks and maintaining physical distance while indoors, can minimize risk to children. We need to encourage those practices as much as possible.

However, contracting the virus isn't the only way our children's lives have been altered by this pandemic.

Risks of exposure to COVID-19 last year led many parents to forgo their child's

visit to the doctor, leading to nearly 12 million fewer routine immunizations.

At the same time, other respiratory infections have surged or waned at atypical times, placing additional uncertainty and capacity challenges on children's hospitals. The pandemic has also had severe consequences on the mental health and wellbeing of America's youth. Even prior to the pandemic, adolescents in the United States experienced an epidemic of poor mental health—with increasing rates of stress, anxiety, depression, and suicidal thoughts and attempts.

As America's youth continue to face compounding stress from the pandemic, we must talk openly about children's mental health and the care they need—not just

care when they are in crisis, but services to maintain their mental health.

While Congress has taken numerous steps to address some of COVID-19's impacts and the resulting needs of children, today's witnesses can share their expertise and provide answers on what more Congress and the American people can do to help ease the challenges children continue to confront.

To that end, I am pleased that as we focus on young people today, a young person

is here to share her perspective.

We all want what is best for our children: We all want to keep our kids healthy

and safe.

United by that common purpose, we must continue to work together to reduce the risks our children face and do everything within our power to protect their health and wellbeing.

We all want an end to COVID-19 in our classrooms and in our communities. As Chair of this Subcommittee, I will continue to make ending the pandemic my top priority.

Ms. DEGETTE. With that, I will yield 5 minutes to the ranking member for his opening statement.

## OPENING STATEMENT OF HON. H. MORGAN GRIFFITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. GRIFFITH. Thank you very much. Appreciate it, Chairman DeGette, and I appreciate you holding this hearing.

Overall, children are at a lower risk than adults for severe illness, hospitalization, and death due to COVID-19, but there is still a risk, particularly for those who are unvaccinated.

After a decline of cases in children earlier this summer, cases in children have increased again and are currently making up 28.9

percent of reported COVID-19 cases.

It is still unclear as to the definitive underlying reasons for this change. Some have hypothesized that these trends might be due to the Delta variant's high transmission rate. Others have suggested that it might be because many adults are now protected by vaccines and, therefore, adults are making up a smaller proportion of the reported infections and hospitalizations. Others think it might be because many children who largely stayed at home last year are now going outside of their homes more, creating increased exposure to the virus compared to what they experienced over the last year and a half.

It is also likely that it is a combination of all of these factors, but it is important that we continue to study these trends to better understand the risk of COVID-19 in children.

I understand that parents are worried about safety of their children and want to ensure that their kids are safe. I have schoolaged children, and I share that concern. We owe it to our kids to keep them safe and to do so by following the science.

In addition to keeping our children safe from getting infected with COVID-19, it is important to look at the impacts of COVID-

19 on our children holistically, because it is not just the SARS-CoV-2 virus that can cause harm to our children. Many of our children are suffering from elevated levels of anxiety, depression, obesity, and eating disorders, or lagging in educational and social development resulting from the pandemic and school closures.

There have also been concerns over increases in abuse and neglect of children during the COVID-19 pandemic and the impacts of many schools teaching remotely, since educators are mandatory reporters and serve as our primary reporters of the abuse and neglect of children in the United States.

These concerns underscore the need for our children to remain in school for in-person learning. Thankfully, children can be back

in school and be safe. The two are not mutually exclusive.

I call on all States and local districts to focus on keeping schools open, prioritize our children, not political mantras.

The Centers for Disease Control and Prevention, CDC, recommends that everyone 12 years of age and older get vaccinated.

In addition, vaccine manufacturers continue to conduct clinical trials and collect data on vaccines for children 11 years of age and younger. In fact, Pfizer and BioNTech recently announced that its COVID-19 vaccine is safe and appears to generate a robust immune response in a clinical trial of children 5 to 11 years old and plans to submit data to the U.S. Food and Drug Administration and other health regulators as soon as possible.

Furthermore, Moderna expects to have data about its vaccine ef-

ficacy for children in the late fall or early winter.

I encourage all parents and children to talk to their doctors about getting the COVID-19 vaccine.

Another tool in our toolbox to keep children safe is accessible testing. Children experience symptoms that are consistent with COVID-19 symptoms for a variety of reasons. Thus, there needs to be a robust and regular testing strategy to prevent the spread of COVID-19 in schools, prevent schools from unnecessarily quarantining children and their families, and to avoid reverting back to exclusively remote learning.

I look forward to today's discussion and learning more about how best to keep our children safe, not just from the virus itself but

from the secondary harms of the virus.

I thank our witnesses for being here today, and for those that are with us virtually, and for being a part of this important discussion. I yield back.

[The prepared statement of Mr. Griffith follows:]

## PREPARED STATEMENT OF HON. H. MORGAN GRIFFITH

Thank you, Chair DeGette, for holding this hearing.

Overall, children are at lower risk than adults for severe illness, hospitalization, and death due to COVID-19, but there is still a risk, particularly for those who are unvaccinated. After a decline of cases in children earlier this summer, cases in children have increased again and currently make up 28.9 percent of all reported COVID-19 cases.1

It is still unclear as to the definitive underlying reasons for this change. Some have hypothesized that these trends might be due to the Delta variant's high trans-

<sup>&</sup>lt;sup>1</sup>Children and COVID-19: State-Level Data Report, American Academy of Pediatrics, available at https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state-level-data-report/.

mission rate, others have suggested that it might be because many adults are now protected by vaccines and therefore adults are making up a smaller proportion of the reported infections and hospitalizations. Others think it might be because many children who largely stayed home last year are now going outside of their homes more, creating increased exposure to the virus compared to what they experienced over the last year and a half. It is also likely that it is a combination of all of these factors, but it is important that we continue to study these trends to better understand the risk of COVID-19 in children.

I understand that parents are worried about the safety of their children and want to ensure that their kids are safe. I have children and share that concern. We owe it to our kids to keep them safe, and to do so by following the science.

In addition to keeping our children safe from getting infected with COVID-19, it is also important to look at the impacts of COVID-19 on our children holistically because it is not just the SARS-CoV-2 virus that can cause harm to our children. Many of our children are suffering from elevated levels of anxiety, depression, obesity or eating disorders, and lagging educational and social development resulting from the pandemic and school closures.

There have also been concerns over increases in abuse and neglect of children during the COVID-19 pandemic and the impacts of many schools teaching remotely, since educators are mandatory reporters and serve as our primary reporters in the

These concerns underscore the need for our children remain in schools for in-person learning. Thankfully, children can be back in schools and be safe—the two are not mutually exclusive. I'd call on all States and local districts to focus on keeping schools open. Prioritize our children, not politics. Even President Biden recently agreed: "if schools follow the science and implement safety measures children can be safe in schools, safe from COVID-19." Let's make sure we are living up to that

promise.

The Centers for Disease Control and Prevention (CDC) recommends that everyone 12 years of age and older get vaccinated. In addition, vaccine manufacturers continue to conduct clinical trials and collect data on vaccines for children 11 years of age and younger. In fact, Pfizer and BioNTech recently announced that its COVID-19 vaccine is safe and appears to generate a robust immune response in a clinical trial of children aged 5 to 11 years-old, and plans to submit the data to the U.S. Food and Drug Administration (FDA) and other health regulators as soon as possible. In addition, Pfizer-BioNTech expects to release clinical trial data for children aged 6-months to 5-years old as early as the end of October. Furthermore, Moderna expects to have data about its vaccine efficacy for young children in the late fall or early winter. 6 I encourage all parents and children to talk to their doctors about getting the COVID-19 vaccine.

Another tool in our toolbox to keep children safe is accessible testing. Children experience symptoms that are consistent with COVID-19 symptoms for a variety of reasons. Thus, there needs to be a robust and regular testing strategy to prevent the spread of COVID-19 in schools, prevent schools from unnecessarily quarantining children and their families, and to avoid reverting back to remote learning.

I look forward to today's discussion and learning more about how best to keep our children safe, not just from the virus itself, but from the secondary harms of the virus. I thank the witnesses for being here today and being part of this important discussion. I yield back.

<sup>&</sup>lt;sup>2</sup> Elizabeth York Thomas, Ashri Anurudran, et al., Spotlight on child abuse and neglect response in the time of COVID-19, Elsevier Public Health Emergency Collection, Lancet Public Health (June 30, 2020), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7326432/.

<sup>3</sup> Remarks by President Biden on How the Administration Is Helping to Keep Students Safe in Classrooms, Brookland Middle School, Washington, DC (Sept. 10, 2021), available at https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/09/10/remarks-by-president-biden-on-low-the-administration is helping to keep students sefe in classrooms/

sponse in kids ages 5 to 11, CNBC (Sept. 20, 2021), available at https://www.cnbc.com/2021/09/20/pfizer-covid-vaccine-is-safe-generates-robust-immune-response-in-kids-ages-5-to-11.html.

<sup>5</sup>Berkeley Lovelace Jr., Pfizer CEO says Covid vaccine data for kids under age 5 may come in late October, CNBC (Sept. 14, 2021), available at https://www.cnbc.com/2021/09/14/pfizers-covid-vaccine-data-for-kids-under-age-5-may-come-in-late-october-ceo-says-.html?utm—source=newsletter-water—medium=email&utm—campaign=newsletter—axiosvitals&stream=top.

<sup>6</sup>Aria Bendix, Vaccines could get authorized young kids this fall. Here are the drug companies' most likely timelines, BUSINESS INSIDER (Aug. 31, 2021), available at https://www.businessinsider.com/when-can-young-kids-get-vaccinated-timeline-2021-7.

Ms. DEGETTE. I thank the gentleman.

The Chair now recognizes the chairman of the full committee, Mr. Pallone, for 5 minutes for an opening statement.

# OPENING STATEMENT OF HON. FRANK PALLONE, Jr., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairwoman DeGette.

The COVID-19 pandemic has been one of our Nation's most challenging periods. This committee has worked tirelessly to ensure that the Nation has the resources necessary to combat the pandemic. And I wanted to also thank Chair DeGette for her continued subcommittee's laser focus on efforts to end the pandemic.

Helping Americans navigate safely through this public health crisis has been at the heart of these efforts, and today we continue that focus by examining the ways the pandemic is affecting our

children.

And as kids across the country head back to school, communities and families are now struggling with the Delta variant, a far more infectious version of the virus.

Experts refer to the current wave of infections, and I quote, as "a pandemic of the unvaccinated"—and yet, while safe and effective vaccines are available to American adults and adolescents, children under the age of 12 are not yet eligible for these vaccines.

As the more contagious Delta variant continues to spread, the number of children with COVID-19 continues to climb. Pediatric units around the Nation, but particularly in States with low vaccination rates, are seeing a surge in hospitalizations. And this is understandably concerning to parents who just want to keep their children safe

Now, it's on all of us to do everything that we can to keep these kids safe. We all have a part to play in getting vaccinated, practicing safety precautions, and looking out for one another. Critically, it's important that government leaders follow the science so that we keep our children safe. And State and local actions that ignore or even contradict the science put our children at risk and undermine our ability to end the pandemic.

It's also important to understand that children are experiencing this pandemic differently than adults. Difficult choices are often made for them by parents, caregivers, and teachers. And more than ever before, children and their families are being forced to balance

numerous complicated risks.

The mental health of our children, in particular, is of grave concern. There were already challenges in addressing the mental health needs of children before the pandemic. But those have been exacerbated by increased social isolation, missed milestones such as graduations, and sick or lost family members, friends, or caregivers. So we have to continue to find ways to address the mental health needs of our kids so that they not only survive through the pandemic but thrive once it's over.

So this committee, Congress, and the Biden administration have taken important steps in providing schools, healthcare institutions, and families with much-needed resources. Earlier this year, Congress passed the American Rescue Plan, which provided funding for the safe operation of schools and expansion of pediatric mental healthcare. And just last week, this committee passed the Build Back Better Act, which among other critical public health provisions includes a permanent extension of the Children's Health Insurance Program, or CHIP, and investments in children's mental health programs.

The Biden administration has taken bold action to support the safe reopening of schools. This includes significant efforts to increase the vaccination rate of adults and children over 12, which can build a blanket of protection for the children around them.

I'm also encouraged by reports that at least one vaccine manufacturer may be submitting an application for a COVID-19 vaccine for children very soon, and the FDA has said it intends to act on that application when it comes within a matter of weeks.

And the Centers for Disease Control and Prevention has issued critical guidance throughout the pandemic, including guidance for healthcare providers, community and business leaders, and recent guidance for educators and school administrators. So it will continue to take all of us working together to keep our children safe.

I thank our witnesses for joining us today to share their expertise and perspectives on what more we can do to protect America's children. And together we have to navigate the challenges of providing for safety of the Nation's children and do everything in our power to ensure health and promising futures.

I just want to thank Chair DeGette again for another important hearing with your O&I Subcommittee. I do think this is really important. Thank you, Diana.

I yield back.

[The prepared statement of Mr. Pallone follows:]

## PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

The COVID-19 pandemic has been one of our nation's most challenging periods. This Committee has worked tirelessly to ensure that the nation has the resources necessary to combat the pandemic, and I want to thank Chair DeGette for her Subcommittee's continued laser focus on efforts to end the pandemic.

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As kids across the country head back to school, communities and families are now struggling with the Delta variant, a far more infectious version of the virus.

Experts refer to the current wave of infections as a "pandemic of the unvaccinated." And yet, while safe and effective vaccines are available to American adults and adolescents, children under the age of 12 are not yet eligible for those vaccines. As the more contagious Delta variant continues to spread, the number of children with COVID-19 continues to climb. Pediatric units around the nation, but particularly in states with low vaccination rates, are seeing a surge in hospitalizations. This is understandably concerning to parents who just want to keep their children safe.

It is on all of us to do everything that we can to keep them safe. We all have a part to play in getting vaccinated, practicing safety precautions, and looking out for one another. Critically, it is important that government leaders follow the science so that we keep our children safe. State and local actions that ignore or even contradict the science put our children at risk and undermine our ability to end this pandemic.

It is also important to understand that children are experiencing this pandemic differently than adults. Difficult choices are often made for them by parents, caregivers, and teachers. And, more than ever before, children and their families are being forced to balance numerous, complicated risks.

The mental health of our children, in particular, is of great concern. There were already challenges in addressing the mental health needs of children before the pandemic. Those challenges have been exacerbated by increased social isolation; missed milestones such as graduations; and sick or lost family members, friends, or caregivers. We must continue to find ways to address the mental health needs of our children so that they not only survive through the pandemic but thrive once it is over.

This Committee, Congress, and the Biden administration have taken important steps in providing schools, health care institutions, and families with much-needed

resources.

Earlier this year, Congress passed the American Rescue Plan, which provided funding for the safe operation of schools and expansion of pediatric mental health care. And just last week, this Committee passed the Build Back Better Act, which among other critical public health provisions, includes a permanent extension of the Children's Health Insurance Program and investments in children's mental health

programs

The Biden administration has taken bold action to support the safe reopening of schools. This includes significant efforts to increase the vaccination rate of adults and children over 12, which can build a blanket of protection for the children around them. I am also encouraged by reports that at least one vaccine manufacturer may be submitting an application for a COVID-19 vaccine for children very soon. The Food and Drug Administration has said it intends to act on that application when it comes within a matter of weeks.

And the Centers for Disease Control and Prevention has issued critical guidance throughout the pandemic, including guidance for health care providers, community and business leaders, and recent guidance for educators and school administrators. It will continue to take all of us working together to keep our children safe. I

It will continue to take all of us working together to keep our children safe. I thank our witnesses for joining us today to share their expertise and perspectives on what more we can do to protect America's children as we strive to end the pandemic. Together, we must navigate the challenges of providing for the safety of the nation's children and do everything in our power to ensure healthy and promising futures.

## Ms. DeGette. I thank the chairman.

The Chair now recognizes the ranking member of the full committee, Mrs. Rodgers, for 5 minutes for purposes of an opening statement.

## OPENING STATEMENT OF HON. CATHY McMORRIS RODGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mrs. Rodgers. Thank you, Madam Chair.

This pandemic has taken a toll on all of us. It's been a challenging time for everyone, especially for those who've lost loved ones. Let me be clear: My heart breaks for any parent who's had to bury their child.

One death from COVID is too many, but we need to recognize what our response is doing to kids. CNN and MSNBC will have you believe that the greatest threat to America's children is COVID-19. They're wrong. And the fear mongering is making it impossible for parents to assess risk and make the best decisions for their kids.

The truth? If infected with COVID-19, children ages 0 to 9 have about a 0.1 percent chance of being hospitalized. Ages 11 to 19 is about 0.2 percent.

Recent data from the Public Health of England found that COVID-19 poses a lower risk of hospitalization to unvaccinated children than it does to fully vaccinated 40-to-49-year-olds.

According to the American Academy of Pediatricians, 0.00 percent to 0.03 percent of all reported child COVID-19 cases have resulted in deaths.

I know the Delta variant is scary. It's more infectious. But from what we've seen so far, it is not more severe. Rather than accept this reality, too many of our leaders and people like President Biden want us to continue to live in fear.

Because of that fear, too many continue to push policies focused only on COVID-19 and cruel restrictions—restrictions that they don't even want to follow themselves. This is all eroding trust,

eroding trust in public health.

Where is the consideration of other aspects of health and children's overall well-being and mental health? Our children are in crisis. Emergency room visits for mental health for children ages 5 to 11 and 12 to 17 increased by 24 percent and 31 percent since the start of this pandemic. Visits for suicidal ideation, attempts, and self-harm among children rose by more than 2.5 times.

What about their education and future? One study found that each month of school closures cost students between 12,000 and

15,000 in future earnings.

In Maryland, 41 percent of all Baltimore City high school stu-

dents earned below a 1.0 GPA in 2020.

What about their social, emotional, and physical development? Mask-wearing and social isolation is taking a toll. Shutdowns and isolation contributed to children and teens gaining weight at an alarming rate.

This was a COVID-19 policy that actually made children more unhealthy and more at risk to COVID-19. How is that following

the science?

Our kids are in crisis, and, unfortunately, this administration is

more focused on political allies than science.

What happened to leading with science? President Biden's administration is guilty of what Democrats claimed of the Trump administration: prioritizing politics over science.

In May, CDC was exposed for working with some of Biden's biggest campaign donors, powerful teachers unions, to draft what was supposed to be the scientific guidance for schools. Thanks to the teachers unions' influence, the guidance put out by CDC likely led to more school closures. Six-feet social distancing was a major roadblock to keeping schools open.

And, although CDC Director Walensky recommended 3 feet to her hometown prior to running for CDC, when she became Direc-

tor, she kept it at 6 feet. Ask yourself why.

Recently, we saw Biden's CDC ignore science and again cave to the teachers union. On May 13th, the CDC announced that fully vaccinated Americans could stop wearing masks indoors. It upset the teachers union.

After receiving private threats about public statements criticizing the administration, the CDC promptly issued an update. Now, all people in schools should wear masks regardless of vaccination sta-

It's even more concerning when you realize that the U.S. is an outlier for COVID-19 policies for kids. Our CDC recommends masking kids 2 and older, but international partners do not. The European CDC recommends masking adults, not kids, in primary schools.

The World Health Organization and UNICEF specifically recommend against masking kids under age 5 and under. For kids 6 to 11, they actually consider other factors when making decisions about masks-the impact on learning and social development. So why don't we? I would submit today that we should. We must put our kids first.

I yield back.

[The prepared statement of Mrs. Rodgers follows:]

## PREPARED STATEMENT OF HON. CATHY McMorris Rodgers

This pandemic has taken a toll on all of us. It has been a challenging time for everyone, particularly for those who have lost loved ones.

Let me be clear: no parent should have to bury their child. One death from COVID-19 is too many.

But we need to have an honest conversation about what our response is doing to

CNN and MSNBC will have you believe the greatest threat to America's children is COVID-19.

They are wrong ...

.. and their fear mongering is making it harder for parents to assess risks and make the best decisions for their children.

The truth?

• If infected with COVID-19, children ages 0 to 9 have about a 0.1 percent chance

of being hospitalized. for ages 11 to 19, it is about 0.2 percent.

• Recent data from Public Health of England found that COVID-19 poses a lower risk of hospitalization to unvaccinated children than it does to fully vaccinated 40 to 49-year-olds.

• According to the American Academy of Pediatrics, 0.00 percent to 0.03 percent of all reported child COVID-19 cases have resulted in deaths.

I know the Delta variant is scary.

It is more infectious—but from what we have seen so far, it is not more severe. Rather than accept this reality too many elites and people like President Biden want us to continue to live in fear for more control.

And because of that fear, too many elected officials continue to push policies focused ONLY on COVID-19 and cruel restrictions—restrictions that they themselves don't want to follow.

They are eroding trust in public health.

Where is the consideration of other aspects of health and children's overall wellbeing and mental health?

## OTHER FACTORS

Emergency room visits for mental health for children ages 5 0911 and 12 0917 increased by 24 percent and 31 percent since the start of the pandemic.

Visits for suicidal ideation, attempts, and self-harm among children rose by more than 2.5 times.

What about their education and future?

One study found that each month of school closures cost students between \$12,000 and \$15,000 in future earnings.

In Maryland, 41 percent of all Baltimore City high school students earned below a 1.0 GPA in 2020.

What about their social, emotional, and physical development?

Mask-wearing and social isolation are taking a toll.

Shutdowns and isolation contributed to children and teens gaining weight at an alarming rate.

This was a COVID-19 policy that actually made children more unhealthy and more at risk to COVID-19. How is this following the science?

Our kids are in crisis, and unfortunately, this Administration is more focused on political favors, than science.

## SCHOOL POLICIES

President Biden promised he would lead with science and truth.

But his administration is guilty of what Democrats claimed of the Trump Administration: prioritizing politics over science.

In May, the CDC was exposed for working with some of Biden's biggest campaign donors—powerful teachers' unions—to draft what is supposed to be scientific guidance for schools.

Thanks to the teachers' unions influence, the guidance put out by the CDC likely led to MORE school closures.

6 feet of social distancing was a major roadblock to keeping schools open—and although CDC Director Walensky recommended 3 feet to her hometown prior to running the CDC, when she became Director, she kept it at 6 feet.

Ask yourself why.

Recently, we saw Biden's CDC ignore science and AGAIN cave to teachers' unions. On May 13, the CDC announced that fully vaccinated Americans could stop wearing masks indoors-which upset the teachers unions.

After receiving private threats about public statements criticizing the Administration, the CDC promptly issued an update—now all people in schools should wear masks regardless of vaccination status.

U.S. v. EUROPE

It is even more frustrating when you realize the U.S. is an outlier for COVID-19 policies for kids.
Our CDC recommends masking kids 2 years and older, but our international part-

ners do not.

The European CDC recommends masking adults, but not kids in primary schools. The World Health Organization and UNICEF specifically recommend against masking children aged 5 and under.
For children ages 6 0911, the WHO and UNICEF actually consider other factors

when making decisions about masks-among them, the impact of on learning and social development.

Why don't we?

It is time the U.S. consider the safety and overall well-being of our children.

Let's put our kids first. Thank you. I yield back.

Ms. Degette. The Chair now asks unanimous consent that all Members' written opening statements be made part of the record. And, without objection, they will be entered in.

I now want to introduce the witnesses for today's hearing.

Dr. Lee Savio Beers, the president of the American Academy of Pediatrics; Dr. Margaret Rush, president, Monroe Carell Jr. Children's Hospital at Vanderbilt—welcome; Dr. Arthur Evans, the chief executive officer at the American Psychological Association; Kelly Danielpour, who will be appearing virtually, who is the founder of VaxTeen. And if you haven't read Kelly's resume, it's incredibly impressive the work that Kelly has done. And Dr. Tracy Beth Hoeg, who's an epidemiologist and public health expert and private practice physician.

With that, welcome everybody. We're excited to hear what you

say from a scientific and personal perspective.

And I am sure you all know that this committee takes its testimony under oath because we're having an investigative hearing.

Does anybody have any objection to testifying under oath? Let the record reflect that the witnesses responded no.

The Chair then advises everyone that, under the rules of the House and the rules of the committee, you are entitled to be accompanied by counsel.

Does anyone here wish to be accompanied by counsel? Let the record reflect that the witnesses nodded no.

So if you would, please rise and raise your right hand so you may be sworn in.

[Witnesses sworn.]

Ms. DEGETTE. You may be seated.

And let the record reflect that all the witnesses responded affirmatively.

And you're now under oath and subject to the penalties set forth in title 18, section 1001, of the United States Code.

Now, at this point, the Chair will recognize each witness for 5 minutes to provide their opening statement. So before I begin, I want to explain the lighting system for the people who are testi-

fying in person.

In front of you is a series of lights. The light will initially be green. The light turns yellow when you have 1 minute remaining, and so please begin to wrap up your testimony. The light will turn red when your time expires. And I will let you finish your sentence, don't worry.

For witnesses testifying remotely, you will see a timer on your screen that will count down your remaining time.

And so now, Dr. Beers, I am very pleased to recognize you for 5 minutes.

STATEMENTS OF LEE BEERS, M.D., PRESIDENT, AMERICAN ACADEMY OF PEDIATRICSM; MARGARET G. RUSH, M.D., PRESIDENT, MONROE CARELL JR. CHILDREN'S HOSPITAL AT VANDERBILT; ARTHUR C. EVANS, JR., PH.D., CHIEF EXECUTIVE OFFICER, AMERICAN PSYCHOLOGICAL ASSOCIATION (APA); KELLY DANIELPOUR, FOUNDER, VAXTEEN; AND TRACY BETH HOEG, M.D., PH.D., EPIDEMIOLOGIST AND PUBLIC HEALTH EXPERT, PRIVATE PRACTICE PHYSICIAN

## STATEMENT OF LEE BEERS, M.D.

Dr. BEERS. Thank you so much, Chairwoman DeGette, Ranking Member Griffith, Chairman Pallone, and Ranking Member McMorris Rodgers, and members of the committee. Thank you so much for the opportunity to speak with you today.

I'm Lee Beers, a pediatrician and president of the American Academy of Pediatrics, or AAP, which represents over 67,000 pedi-

atricians across the country.

I agree the past 18 months have been extremely challenging for America's children, and pediatricians have seen firsthand the impact of COVID on children, both directly and indirectly.

While COVID-19 infection is generally not as severe in children as adults, lower risk does not mean no risk, and many children

have become very sick from COVID-19.

According to information compiled by AAP and the Children's Hospital Association, to date more than 5.5 million children have been infected by the virus since the start of the pandemic, over 21,000 children have been hospitalized, and 480 children have died as a result of COVID-19.

Even more tragically, in many cases these hospitalizations and deaths could have been prevented through safe and simple measures. More than two-thirds of these deaths have been in Black and Latinx children, which shows the disproportionate effects of the virus on children of color.

While studies have shown that the Delta variant may not cause more severe cases of COVID-19, it is indeed more transmissible. In recent weeks, we've seen about a quarter million new cases reported in children each week, reaching levels even higher than we saw during the spike last winter.

And, fortunately, we know what to do to reverse this concerning trend. Vaccines are the key to dramatically decreasing the spread of the virus and allowing children to return fully to doing all the things they love to do and that help them thrive.

Thankfully, a safe and effective COVID vaccine has been available for adolescents 12 and older since May. But, unfortunately, vaccination for adolescents lags behind adults. Only 54 percent of 12-to-17-year-olds have yet been vaccinated, compared to over 76 percent of adults.

And while we have more work to do to increase vaccination among older children, we are hopeful that a vaccine for children

ages 5 to 11 will also be authorized soon.

We believe the FDA has the right regulatory approach in place so that when it authorizes a vaccine for younger children, we can

be highly confident that it's safe and effective.

We also cannot forget that we have work to do to ensure children receive their routine vaccinations that protect them against serious preventable diseases, such as measles, hepatitis, and rotavirus. Children have missed millions of doses since the start of the pandemic because many missed their checkups.

And one of the primary barriers to improved vaccination rates overall is vaccine hesitancy. Many parents have fairly typical concerns about the potential side effects of vaccines, and these concerns can usually be addressed through education from trusted community members like pediatricians.

But the level of misinformation and disinformation about COVID vaccines that's been circulating online has been astounding, and

this has proven much more difficult to address.

Sadly, many pediatricians have also been personally targeted with attacks as a result of this misinformation. Pediatricians I've personally spoken to and their staff have been harassed, booed, spit upon, and threatened. Some have had to implement increased security in their home and work.

Needing to defend and protect oneself against these baseless personal attacks distracts and diverts resources from our ability to

provide care for children and families.

I urge us all to come together in a coordinated national effort to fight misinformation, reestablish our trust in science, and support those on the front lines working to end this pandemic.

At this point, the COVID-19 pandemic has disrupted 3 separate school years for children across this country, with wide-ranging impacts not only on children's educational attainment but also their social, emotional, behavioral, and physical health.

Because of the invaluable role that schools and in-person learning play in a child's development and well-being, the AAP has strongly advocated that we do everything we can to keep children safe so they can attend school in person. To do this, it's imperative for schools to employ multilayered protective measures to keep the school community safe until vaccination rates are high enough to significantly reduce the spread of COVID-19.

At this time, pediatricians recommend universal masking in school for all students older than 2 years and all school staff, unless medical or developmental conditions prohibit use, as well as a number of other straightforward, simple, and layered measures.

I want to end today by addressing the mental health challenges of children and families. Emotional and behavioral health needs in children and adolescents were a growing concern well before the COVID-19 pandemic, but the pandemic has acutely exacerbated these challenges to near crisis levels.

Now more than ever, families and children from infancy through adolescence need access to mental health screenings, diagnostics, and the full array of evidence-based therapeutic services to appropriately address their needs.

But there are many barriers to these services in the community. My written testimony identifies a number of these opportunities for Congress to address these barriers, and I'm happy to answer questions.

We look forward to working with the committee on this critical issue. Thank you so much for inviting me to testify today, and I look forward to your questions later.

[The prepared statement of Dr. Beers follows:]



Testimony of Dr. Lee Beers, MD, FAAP President, American Academy of Pediatrics

Before the House Energy and Commerce Oversight and Investigations Subcommittee

"Putting Kids First: Addressing COVID-19's Impact on Children" September 22, 2021

Chairwoman DeGette, Ranking Member Griffith and members of the committee, thank you for the opportunity to testify before you today. It is my pleasure to be here to talk about the impact of the COVID-19 pandemic on children at this crucial time with the Delta variant surging and children across the country returning to the classroom.

My name is Dr. Lee Beers and I am testifying today as the president of the American Academy of Pediatrics (AAP), a non-profit professional membership organization of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health and well-being of children. I am a Professor of Pediatrics at Children's National Hospital in Washington, DC, where I serve as the Medical Director of Community Health and Advocacy in the Child Health Advocacy Institute and lead our Community Mental Health CORE. I also co-direct the Early Childhood Innovation Network, a local collaborative that works to promote the healthy development of young children who are exposed to early childhood adversity.

## Pediatric COVID-19 Cases and the Delta Variant

The past 18 months have been extremely challenging for adults and children alike. I can tell you that pediatricians have seen first-hand the impact of COVID on children – both directly and indirectly. While COVID-19 infection is generally not as severe in children as adults, children have not been spared by the virus. Lower risk does not mean no risk, and many children have become very sick from COVID-19.

As of September 16, more than 5.5 million children have been infected by the virus since the start of the pandemic, representing more than 15 percent of the total cumulative cases. Over 21,000 children have been hospitalized and 480 children have died as a result of COVID-19.¹ Recent CDC data shows that COVID-19—associated hospitalizations rates are 2.5—3.0 times higher than influenza-associated hospitalizations.² Among deaths attributed to COVID-19, more than two-thirds of these have been in Black and Latinx children. In addition, COVID-19 is currently one of the ten leading causes of death for children in the United States.³

Unfortunately, with the spread of the Delta variant that has overwhelmed the entire country this summer and fall, we are seeing an extraordinary rise in case numbers in children. After declining in early summer, child cases have increased exponentially, with over a million new cases between August 5 and September 16. In fact, more than 225,000 cases were added just this past week, for an increase of about 469,000 cases in the past two weeks.

The rise in overall case numbers is also resulting in more and more children needing to be hospitalized due to contracting COVID-19. A Centers for Disease Control and Prevention (CDC) study published in the Morbidity and Mortality Weekly Report (MMWR) on September 3 showed that COVID-19 cases, emergency department visits and hospital admissions increased from June to August 2021 among children aged 0-17 years.<sup>4</sup> The report found that emergency department visits and hospital admissions in the 2-week period from August 14-27, 2021 quadrupled in states with lower population vaccination coverage compared with states with higher vaccination coverage. The study also determined that while the spread of the Delta variant has caused a higher number of hospitalizations, the severity of cases amongst those admitted to the hospital are not significantly different. In other words, while the Delta variant may not cause more severe cases of COVID-19 than previous variants, it is much more transmissible and, as a result, more children are becoming infected and a corresponding increased number of children need to be hospitalized. As such, these findings underscore the importance of community vaccination, in coordination with testing strategies and other prevention measures, to decrease the overall spread of COVID-19 in communities and to protect children from preventable illness.

### Pediatric COVID-19 Vaccine Development and Authorization

Thankfully, through the incredible work of the federal government, researchers, and vaccine manufacturers, vaccines have been available for Americans 16 and older since January, and for adolescents 12 and older since May. While the vaccine development occurred at an unprecedented pace, no corners were cut in the development of these vaccines and each followed the stringent Food and Drug Administration (FDA) guidelines and standards as they were studied. Each vaccine was also developed and evaluated at different points in time against different strains of COVID-19 within distinct geographic regions and populations and were found to be highly effective against severe COVID-19 illness, hospitalization, and death.

In addition, all COVID-19 vaccines are monitored through robust FDA and CDC systems that monitor vaccine safety in the United States. This vaccine safety system includes the Vaccine Adverse Event Reporting System (VAERS), Vaccine Safety Data Link (VSD), Clinical Immunization Safety Assessment (CISA), and V-SAFE, a new smartphone-based system added to the safety monitoring system specifically to monitor for side effects of the COVID-19 vaccines. These systems have proven that they work.

While the AAP is thankful that adolescents have had a COVID-19 vaccine available to them since May, we are anxiously awaiting a COVID-19 vaccine available to children 11 and under. We are grateful that several vaccine manufacturers have been conducting clinical trials in children 11 and under for a number of months. These clinical trials are extremely important and are essential to understanding the unique immune responses and potential safety concerns in children. In addition, different doses will be needed

for different age groups, so the trials are crucial to determine the most appropriate vaccine dose in vounger children.

The AAP has communicated to FDA that we believe that the rise of the Delta variant in children makes it even more urgent that a vaccine for children under 12 be available as soon as possible. We understand that Pfizer intends to submit data to FDA soon to support an emergency use authorization (EUA) of its vaccine in children ages 5-11. We were pleased by the FDA's statement on September 10 that they will thoroughly and independently examine data submitted by vaccine manufacturers and be prepared to complete their review as quickly as possible, likely in a matter of weeks rather than months. We believe that FDA has the right approach in place for us to be highly confident in their regulatory decision-making with respect to COVID-19 vaccines in children.

### **Pediatric COVID-19 Vaccination Rates**

Vaccines are the key to dramatically decreasing the spread of the virus and allowing children to return to a more normal semblance of life. That is why it is so important that eligible people get vaccinated as soon as possible. While there was an initial rush of adolescents getting the vaccine in the first month following authorization, vaccine uptake has slowed down with each subsequent month. According to the CDC, as of September 15, 2021, 12.7 million US children under age 18 had received at least one dose of COVID-19 vaccine, representing 54 percent of 12–17-year-olds. <sup>6</sup>

Most recently, 273,000 children received their first COVID-19 vaccine the week of September 16. Unfortunately, that number of children receiving their first dose represented a decline for a fifth straight week and is at its lowest level since the vaccine was made available to 12–15-year-olds. In fact, the number of weekly first-dose vaccinations remains far below the peak of 1.6 million at the end of May. Adolescent vaccination rates vary substantially across states. For example, in 15 states, over 60 percent of 12-17-year-olds have received at least one dose, and in 11 states, fewer than 40 percent have received one dose. It is so important that we work to address these geographic disparities so that children everywhere can be protected for COVID-19 and its effects. With the return to school, it is particularly imperative that we redouble our efforts to vaccinate all eligible 12- to 17-year-olds.

## Vaccine Hesitancy

Unfortunately, vaccine hesitancy, which was on the rise in the years leading up to the pandemic, has become even more prominent over the last year and a half, hampering a robust uptake of a COVID-19 vaccine. Some Americans have fairly typical concerns about the potential side effects of COVID-19 vaccines, or the speed at which the vaccines were developed. These concerns can be addressed through careful explanation and education from trusted community members such as pediatricians. But the level of misinformation and disinformation about COVID-19 vaccines circulating online has been astounding, and this has proven more difficult to address. Widespread baseless claims on social media have meant that myself and other medical providers have had to repeatedly correct false claims about the COVID-19 vaccines causing infertility, changing a person's DNA, and magnetizing people. It is hard to keep up with the speed at which this misinformation travels. Many pediatricians have also been personally targeted with on-line and in-person attacks as a result of this misinformation. I have personally been in contact with pediatricians who have been harassed, booed, spit upon and/or threatened. Some have had to implement increased security at their home and work. Needing to justifiably defend and protect one's

Page 3

self and staff against these personal attacks distracts and diverts resources from these professionals' ability to provide the care for children and families their communities need and deserve.

While it is imperative to call out misinformation, it is also important to recognize that the reasons for vaccine hesitancy can vary across communities. Some hesitancy is borne out of lived experiences, particularly among African Americans and other groups which have historically experienced inequitable care. The hesitancy in these communities was highlighted by a survey conducted by the African American Research Collaborative and The Commonwealth Fund in June, which showed that more than 40 percent of Black and Latinx American polled in their American COVID-19 Vaccine Poll were unvaccinated and still hesitant to get a COVID-19 vaccine. But there was also encouraging news in the same poll. Among those surveyed, 60 percent said that their personal doctor/primary care physician was the most effective messenger to encourage them to get a shot. Another 53 percent of those surveyed said they preferred to be vaccinated against COVID-19 vaccine in their doctor's office.

This information underscores the importance of the physician office as a key component in efforts to address lingering doubts about the vaccine and increase vaccine uptake. As pediatricians, we are already seeing how conversations with our adolescent patients and their parents and grandparents have led to us vaccinating entire families against COVID-19. In addition to vaccinating adolescents 12-17, and soon children 5-11, we stand at the ready to help vaccinate the hardest to reach Americans of all ages so we can get vaccines to as many Americans as possible.

## Declines in Routine Childhood Vaccinations and Strengthening the Vaccines for Children Program

Another unfortunate impact of the COVID-19 pandemic has been the detrimental effect it has had on routine childhood immunization rates over the last year and a half. Routine childhood vaccinations protect children against serious and deadly preventable diseases such as measles, hepatitis, and rotavirus. Since early in the pandemic, CDC has warned about significant decreases in orders for vaccines through the federal Vaccines for Children (VFC) program, a key sign that many children were not getting their recommended vaccines. More recent CDC data shows that as of the start of September of this year, overall VFC provider orders (excluding the flu vaccine) remain down by more than 13.2 million doses compared to 2019.<sup>9</sup>

Missed vaccinations leave children at-risk for contracting vaccine-preventable diseases. These vaccinations are typically administered during routine pediatric visits, which have unfortunately seen a notable decline during the public health emergency. Routine well-child visits are a critical opportunity for a child's health care provider to conduct important services such as identifying and diagnosing conditions, tracking developmental milestones, and counseling families on mental and behavioral health issues. We need to work hard to get children back to their usual source of care and get them caught up on their vaccines.

One way we can strengthen the vaccine delivery system for children would be to pass legislation to improve the Vaccines for Children (VFC) program which helps about half of U.S. children receive their recommended vaccines. We appreciate that the House Committee on Energy and Commerce has passed the Strengthening the Vaccines for Children Program Act (H.R. 2347) and we look forward to working with committee members to continue to advance this legislation.

## **Returning Children Safely to In-Person Schooling**

At this point, the COVID-19 pandemic has disrupted three separate school years for students across the country. It has had wide-ranging impacts on not only children's educational attainment, but also their social, mental, emotional, behavioral, and physical health.

Schools and school-supported programs are fundamental to child and adolescent development and well-being. They provide our children and adolescents with academic instruction; social and emotional skills, safety, reliable nutrition, physical/occupational/speech therapy, mental health services, health services, and opportunities for physical activity, among other benefits.

Remote learning as a result of the pandemic highlighted inequities in education, was detrimental to the educational attainment of students of all ages and exacerbated the mental health crisis among children and adolescents. Many families did not have adequate support and disparities, especially in education, worsened, especially for children who are English language learners, children with disabilities, children living in poverty, and children who are Black, Hispanic/Latino, and American Indian/Alaska Native.

Because of the invaluable role that schools and in-person learning play in a child's development and well-being, the AAP has strongly advocated that we do everything we can to keep children safe so they can attend school in-person. The AAP believes that, at this point in the pandemic, given what we know about low rates of in-school transmission when proper prevention measures are used, together with the availability of effective vaccines for those age 12 years and up, that the benefits of in-person school outweigh the risks in almost all circumstances.

Until we are able to increase vaccination enough to significantly reduce the spread of COVID-19, it will be important for schools to continue to employ multi-layered protective measures to keep the school community safe. The implementation of several coordinated interventions, including vaccination for all eligible students and staff, universal masking regardless of vaccination status, and other mitigation strategies like social distancing, washing hands and improved air ventilation, can greatly reduce risk. Combining these layers of protection will make in-person learning safe and possible.

At this time, we recommend universal masking in school for all students older than 2 years and all school staff, unless medical or developmental conditions prohibit use. There are several reasons we recommend universal masking in schools, including the fact that children under 12 years of age are not yet eligible for vaccination. We are also still seeing low vaccination uptake in certain communities across the country and the highly transmissible Delta variant continues to more easily spread among children, adolescents, and adults. Universal masking can help protect unvaccinated students and reduce transmission of COVID-19.

Additionally, many schools do not have a system to monitor vaccine status among students, teachers, and staff, making it likely very difficult to enforce masking policies only for those who are not vaccinated. Therefore, universal masking is the best and most effective strategy to create consistent messages, expectations, and compliance without needing to monitor vaccination status.

## **Emotional and Behavioral Health Needs of Children**

The COVID-19 pandemic has had a profound effect on the emotional and behavioral health needs of children, adolescents, and families. There are many factors unique to this pandemic (e.g., duration of

Page 5

the crisis, rapidly changing and conflicting messages, need for quarantine and physical isolation, and uncertainty about the future) that have increased its effects on emotional and behavioral health. Groups with a higher baseline risk, such as populations of color, communities and families living in poverty, historically under resourced communities, children who are refugees and seeking asylum, children and youth with special health care needs, and children involved with the child welfare and juvenile justice systems, may be especially vulnerable to these effects. The impact of the pandemic is also compounded by the interruption in vital supports and services including school, health care services, and other community supports.

Emotional and behavioral health challenges were of growing concern before the COVID-19 pandemic, and the public health emergency has acutely exacerbated these challenges. The pandemic highlights preexisting disparities in morbidity and mortality, access to health care, quality education, affordable housing, adequate nutrition, and safe environments, which create more challenges and stressors for many families and communities.

The inequities that result from structural racism increase the vulnerability to emergency situations, as evidenced by the disproportionate impacts of COVID-19 on communities of color. Racism operates at the level of individual experiences of discrimination by youth of color as well as the ways in which youth of color have differential access to mental health services and diagnosis and treatment for mental and behavioral health conditions. <sup>10</sup> Additionally, COVID-19 has contributed to increased racism and xenophobia against individuals who are of Asian descent.

LGBTQ youth are at heightened risk for changes in mental health if they are living in homes where they are not supported by their families. The pandemic may isolate them from their supports such as the local LGBTQ center or their LGBTQ friends/community. These youth may be subjected to increased physical or emotional maltreatment from a family member and not have a means to escape it.

For adolescents in the juvenile justice system, visits from family members may be prohibited, which may result in increased isolation, stress, and anxiety/depression in these youth. In addition, youth in the juvenile justice system are at increased risk of exposure to severe acute respiratory syndromes because of crowding and lack of personal protective equipment.

Children and youth with special health needs depend on uninterrupted access to specialized medical and/or mental health services. Interruption of services for these children can increase stress on the family and place the child at risk for losing skills.

As of July 2021, nearly 120,000 children in the U.S. lost a primary caregiver to COVID-19 and nearly 140,000 children lost a primary and/or secondary caregiver with Black youth experiencing the highest rates of loss.<sup>11</sup> The consequences of orphanhood can last a lifetime and special attention must be paid to support these children who face higher risks to their health, safety, and well-being.

For several years, suicide has been the second leading cause of death for youth ages 10-24 in the U.S. but the COVID-19 pandemic has exacerbated the mental health crisis in our nation's young people. <sup>12</sup> Between March and October 2020, the percentage of emergency department visits for children with mental health emergencies rose by 24 percent for children ages 5-11 and 31 percent for children ages

12-17.<sup>13</sup> The CDC also found a more than 50 percent increase in suspected suicide attempt Emergency Department visits among girls ages 12-17 in early 2021 as compared to the same period in 2019. <sup>14</sup>

Children's emotional and behavioral health is greatly impacted by that of their parents and caregivers. Parents and caregivers struggling with their own mental health problems, health issues, substance use disorder, or increased stress due to loss of income, housing, and access to nutrition and other supports during the pandemic may impact the emotional health of children.

Interruptions in regular access to healthy, nutritious foods and the impact of isolation and increased screen time have impacted children's health and wellbeing on both extremes. Recent CDC data show a rise in childhood obesity during the pandemic – about 22 percent of children and teens with obesity last August, up from 19 percent a year ago. <sup>15</sup> These findings mirror what I have seen in my clinic and what pediatricians across the country are reporting. One pediatrician I spoke with saw a child who had gained 90 pounds in the last year, one who had gained 60 pounds, and three who gained 30-40 pounds all in one day in clinic. She was in tears describing it as the most depressing day she's had in clinic for a long time

Relatedly, we are also seeing dramatic increases in eating disorders, a very complicated condition that requires multi-disciplinary treatment. My adolescent medicine and child psychiatry colleagues tell me that not only are they seeing many more cases of eating disorders, but they are more severe and are starting at even younger ages, even down to the age of 8 or 9, and that because of the complexity of the treatment for eating disorders, it is extremely difficult to access fully comprehensive care for patients.

Now more than ever, families and children from infancy through adolescence need access to mental health screening, diagnostics, and a full array of evidence-based therapeutic services to appropriately address their mental and behavioral health needs. Interagency collaboration among the key federal agencies is essential to ensure that existing opportunities are leveraged, and funding-related gaps are identified and addressed. Collaboration across federal agencies will be key to developing a comprehensive system of care across the continuum to address mental and behavioral health needs for infants, children, and adolescents.

Last spring, the AAP, joined by 29 other leading organizations, released a comprehensive set of Child and Adolescent Mental and Behavioral Health Principles that, if enacted in policy, would increase access to evidence-based prevention, early identification, and early intervention; expand mental health services in schools; integrate mental health into pediatric primary care; strengthen the child and adolescent mental health workforce; increase insurance coverage and payment; extend access to telehealth; support children in crisis; and address the mental health needs of justice-involved youth.<sup>16</sup>

The AAP applauds Congress for including an additional \$80 million in the American Rescue Plan for the Pediatric Mental Health Care Access program at the Health Resources and Services Administration which just announced grants to an additional 24 states and territories to enable pediatric mental health teams to provide tele-consultation, training and technical assistance to pediatric primary care practices. As the founding director of DC's program, I can tell you that this model of supporting pediatric primary care practices with telephonic consultation with child mental health teams is helping increase access to mental health services for children. We appreciate that the House FY 2022 Labor-HHS appropriations bill includes a \$15 million increase for this program and we hope the Senate will follow suit.

Sizeable federal resources have been allocated for mental health but we must ensure that this funding goes to helping children and those who care for them. Support for schools with tools to help them access Elementary and Secondary School Emergency Relief (ESSER) funds to support student and staff mental health and well-being is critically important. And we need to ensure that the Centers for Medicare and Medicaid Services is using every authority possible to increase children's access to mental health services wherever they are – at school and early childhood settings, at the pediatrician's office, and in the community.

The AAP applauds the House for passing H.R. 721, the *Mental Health Services for Students Act*, and we urge the Senate to pass it as well. We also urge the House to pass H.R. 5035, the *Child Suicide Prevention and Lethal Means Safety Act*, and H.R. 3549, the *Comprehensive Mental Health in Schools Pilot Program Act of 2021*.

Meanwhile, we need to continue to support families who are struggling to make ends meet. The latest child poverty data released by the Census Bureau show that children have the most gain from federal assistance in preventing deeper poverty and the resultant effects poverty has on child health. The expanded child tax credit and enhanced nutrition assistance during the school year and in the summer are critically important to supporting family's overall well-being and should be extended.

### **Pediatric Mental Health Workforce Needs**

The intensity and stress of caring for patients over the past year and a half of the pandemic, along with grief and anxiety, has impacted the entire medical community. Now, physicians are not only facing a surge of COVID-19, but we are also seeing an uptick in other respiratory illnesses and mental health concerns. Changes in how we practice, financial burdens such as lost revenue and higher expenses, staffing challenges, widespread misinformation, and constant uncertainty about what the future will bring have all added new burdens to the work the medical community is doing every day to care for children and families in our communities. As pediatricians grapple with these issues and more, many are struggling with their own well-being.

Even before the pandemic, mental health data showed that physicians in the United States face higher incidents of suicide than any other profession. The 2018 Medscape National Physician Depression and Burnout Report showed 66 percent of male physicians and 58 percent of female physicians revealed they were experiencing symptoms often referred to as "burnout", depression, or both. The study also discussed that many of the professionals were not seeking help and had no plans to do so because of barriers such as stigma and the professional risks associated with disclosing their treatment activities to medical boards. In the fall of 2020, the National Institute for Health Care Management (NIHCM) Foundation found that 20 percent of surveyed physicians reported symptoms of clinical depression and 13 percent reported suicidal ideation. Nearly 70 percent of doctors said they felt down, blue, or sad. I'm fairly sure the numbers would not be much better today, and they may even be worse.

The AAP is a strong supporter of H.R. 1667, the *Dr. Lorna Breen Health Care Provider Protection Act*, an important proposal that aims to prevent and reduce incidences of suicide, mental and behavioral health conditions among health care professionals, sometimes referred to as "burn out", and substance use

disorders. Through grants, education, and awareness campaigns - the legislation will help reduce stigma and identify resources for health care providers and clinicians seeking assistance. We urge the House to pass this important legislation. We must do all that we can to protect the health and well-being of the medical providers that have sacrificed so much during this pandemic to keep our country safe and healthy. We must also continue to work to ensure that the systems that they practice in are supportive and safe for patients and health care workers alike.

Thank you for the opportunity to testify today, and I look forward to answering your questions.

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<sup>&</sup>lt;sup>1</sup> Children and COVID-19: State Data Report, A joint report from the American Academy of Pediatrics and the Children's Hospital Association, Summary of publicly reported data from 49 states, NYC, DC, PR, and GU, Version: September 16, 2021

<sup>&</sup>lt;sup>2</sup> Havers FP, Whitaker M, Self JL, et al. Hospitalization of Adolescents Aged 12–17 Years with Laboratory-Confirmed COVID-19 — COVID-NET, 14 States, March 1, 2020–April 24, 2021. MMWR Morb Mortal Wkly Rep 2021;70:851–857. DOI: <a href="https://dx.doi.org/10.15585/mmwr.mm7023e1">https://dx.doi.org/10.15585/mmwr.mm7023e1</a>

<sup>&</sup>lt;sup>3</sup> Peterson-KFF Health Systems Tracker, August 27, 2021. COVID-19 continues to be a leading cause of death in the U.S. in August 2021. https://www.healthsystemtracker.org/brief/covid-19-continues-to-be-a-leading-cause-of-death-in-the-u-s-in-august-2021/

<sup>&</sup>lt;sup>4</sup> Siegel DA, Reses HE, Cool AJ, et al. Trends in COVID-19 Cases, Emergency Department Visits, and Hospital Admissions Among Children and Adolescents Aged 0–17 Years — United States, August 2020–August 2021. MMWR Morb Mortal Wkly Rep 2021;70:1249–1254. DOI: <a href="https://dx.doi.org/10.15585/mmwr.mm7036e1">https://dx.doi.org/10.15585/mmwr.mm7036e1</a>
<sup>5</sup> FDA Statement: FDA Will Follow the Science on COVID-19 Vaccines for Young Children.

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<sup>&</sup>lt;sup>6</sup> AAP Children and COVID-19 Vaccination Trends. https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-vaccination-trends/

<sup>&</sup>lt;sup>7</sup> AAP Children and COVID-19 Vaccination Trends. https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-vaccination-trends/

<sup>8</sup> American COVID-19 Poll. The African American Research Collaborative and the Commonwealth Fund. June, 2021
9 Centers for Disease Control, September 2021.

<sup>&</sup>lt;sup>10</sup> Trent, M, Dooley, DG, Dougé, D. The impact of racism on child and adolescent health. *Pediatrics*. 2019;144(2)

<sup>&</sup>lt;sup>11</sup> Children: The Hidden Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/orphanhood-report.pdf

<sup>12</sup> https://wonder.cdc.gov/controller/datarequest/D76;jsessionid=60B91188B5DF590441DAD31FB807

<sup>&</sup>lt;sup>13</sup> Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: <a href="http://dx.doi.org/10.15585/mmwr.mm6945a3external.icon">http://dx.doi.org/10.15585/mmwr.mm6945a3external.icon</a>

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2021. MMWR Morb Mortal Wkly Rep 2021;70:888–894. DOI: <a href="http://dx.doi.org/10.15585/mmwr.mm7024e1">http://dx.doi.org/10.15585/mmwr.mm7024e1</a>
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Ms. DEGETTE. Thank you so much, Dr. Beers.

Dr. Rush, now I'm pleased to recognize you for 5 minutes for an opening statement.

You need to push your button there.

## STATEMENT OF MARGARET G. RUSH, M.D.

Dr. Rush. Chairwoman DeGette, Ranking Member Griffith, and distinguished members of the subcommittee, thank you for the opportunity to testify today. My name is Dr. Meg Rush, and I serve as president of Monroe Carell Jr. Children's Hospital at Vanderbilt on the Vanderbilt University Medical Center campus in Nashville, Tennessee.

I'm truly honored to be here to share the perspectives of children's hospitals as we have navigated the pandemic and appreciate the opportunity to speak more broadly about the pandemic's impact on child health and well-being.

Although COVID-19 is much less likely to lead to death in children, many children are contracting the Delta variant and becom-

ing sick.

Tennessee is one of several southern States where there is some degree of vaccine unreadiness. Our lower rates of vaccination are clearly correlated with the fact that Tennessee is intermittently ranked number one for the highest number of COVID-positive cases in both adults and children as recently as Monday of this week, which, in turn, has resulted in high numbers of hospitalizations.

I want to begin by telling you about Sophia. As she and her parents prepared for the start of kindergarten, neither parent was vaccinated. Within a few days of starting school, Sophia contracted COVID–19 and developed mild symptoms. Unfortunately, both parents became infected and, tragically, neither survived. Sophia, now orphaned, joins 1.5 million children worldwide who has lost a caregiver. She will carry this pain forever.

Children's hospitals account for 2 percent of the hospitals across the United States, yet we are the safety net for all pediatric

healthcare for 20 percent of the Nation's population.

Children's hospitals have experienced the opposite ends of the spectrum over the past 18 months. In 2020, children's hospitals [inaudible] for uncertainty of how COVID-19 would impact children. It turns out that biological differences combined with putting health measures in place not only resulted in comparatively few cases of COVID-19 infection in children but also near disappearance of many other respiratory illnesses of childhood that often result in hospitalization.

Utilization of healthcare by children decreased dramatically, resulting in large volume and revenue shortfalls by both children's hospitals and pediatricians. This revenue shortfall caused staffing downsizing in some children's hospitals. Others such as mine stepped up to help adjacent adult hospitals either by sharing staff,

offering beds, or both.

Entering 2021, modeling suggested that children's hospitals could experience ongoing volume and revenue shortfalls if children continued to be so healthy. But 6 months ago, we saw an unprecedented off-season spike of the typical fall and winter viral infec-

tions. Volumes increased dramatically, with many children becoming critically ill, and in the summer COVID-19 Delta surge began, further compounding ongoing capacity and staffing challenges.

Although children were much less sick last year, their health and well-being was negatively impacted. As we know, children and families across the country faced substantial disruptions to their daily lives due to COVID-19.

The Vanderbilt Child Health Poll conducted in 2020 presents a snapshot of factors that, taken together, negatively impact the health of children, particularly those who face other socioeconomic disadvantages. Changes in insurance, economic instability, increased food insecurity, decreased physical activity, learning, and socialization are all significant factors that impact child health.

Fear of the pandemic also caused some families to delay healthcare for their children even if they were sick. And I would be remiss if I did not mention the parallel behavioral health epidemic that was well underway before the onset of the pandemic but clearly worse now.

Multifactorial in nature, youth from ages 4 to 18 present to children's hospitals in crisis. As acute care hospitals, our options are to hold these patients in our emergency departments or admit them to acute care beds until there is an appropriate safety care plan.

Yesterday, I had 34 children admitted for behavioral health crisis in my hospital. Twenty-four of these were medically cleared but needed an executable care plan for their mental health.

Throughout the pandemic, Congress has provided billions in funding to support clinical care, public health activities, and research and therapies and vaccine development.

As my testimony outlines, there remain opportunities, particularly in the space of health and well-being of children, including legislation put forward by members of the Energy and Commerce Committee.

Thank you in advance for your consideration of supporting the youth in our Nation. Sophia and all like her are truly our future. Thank you.

[The prepared statement of Dr. Rush follows:]

Putting Kids First:
Addressing COVID-19's Impacts on Children
Oversight and Investigations Subcommittee
Energy and Commerce Committee
September 22, 2021

Written Testimony of
Margaret G. Rush, MD, MMHC
President
Monroe Carell Jr. Children's Hospital at Vanderbilt
Professor of Clinical Pediatrics
Vanderbilt University

Chairwoman DeGette, Ranking Member Griffith, Chairman Pallone, Ranking Member McMorris Rodgers and honorable Members of the Committee, thank you for the opportunity to speak to you today about the impact of the COVID-19 pandemic on children, families, and the children's healthcare system from the vantage point of children's hospitals.

My name is Dr. Margaret Rush. I am a pediatrician with specialty board certification in neonatology (newborn intensive care) and have enjoyed a career spanning all components of academic medicine: research, education, clinical care and for the past 17 years, hospital administration, all at Vanderbilt University Medical Center.

I have the privilege of serving as the President of Monroe Carell Jr. Children's Hospital at Vanderbilt, a 343-bed, freestanding hospital with ambulatory clinic space located on the Vanderbilt University Medical Center (VUMC) campus in Nashville, Tennessee. Additionally, we have over 20 offsite and affiliated clinic locations and 11 hospital partnerships that span the state from Memphis in the west to Knoxville in the east.

As the only comprehensive children's hospital in Middle Tennessee, Monroe Carell Jr. Children's Hospital at Vanderbilt serves almost half of the 95 counties in the state of Tennessee. For 15 consecutive years, we have been ranked among the best children's hospitals in the nation and

this year, earned the distinction as the No.1 children's hospital in Tennessee and the southeast region. Our Department of Pediatrics has the 4<sup>th</sup> highest level of NIH funding of a department of pediatrics in the United States (\$46 million)<sup>1</sup> and is home to some of the world's leading pediatric scientists, including many internationally recognized pediatric infectious disease experts who have contributed to understanding the biology of the SARS-CoV-2 virus and to the development of COVID-19 treatments and vaccines, clinical trials in adults and children, clinical guidelines for testing children and finally advising public health officials working to control the pandemic.

Although COVID-19 is much less likely to lead to death in children, many children are contracting the Delta variant and becoming sick. COVID-19 has an immediate and lasting impact on the entire community. I want to tell you about a pediatric patient Sophia. Like children across the country, Sophia and her parents were excited for the school year. As Sophia prepared to start kindergarten, neither her mother, a schoolteacher, nor her father, who worked in a small business, were vaccinated. Within a few days of starting kindergarten, Sophia contracted COVID-19, developed mild symptoms and did not require hospitalization. But her mother then her father both became infected, critically ill and tragically, neither survived. Sophia is now orphaned without parents and joins the 1.5 million children world-wide who has lost a primary or secondary caregiver to COVID-19.

Sadly, this story is one of three like it that I heard from various colleagues the past two weeks. Sophia, now five, will carry this pain forever. There should be no question that this pandemic has negatively impacted the health and well-being of children, now and perhaps well into the future.

Children are often a secondary thought when considering major societal decisions. Yet, they are our future. This story and others like it, sadly illustrate the issues we have faced throughout the pandemic from a societal perspective. Though schools immediately pivoted to protect students,

teachers, and coaches in March of 2020 and through the fall of 2020, many have relaxed or eliminated infection prevention measures this school year.

Tennessee is one of a number of southern states where there is a degree of vaccine unreadiness and misinformation. Relatively low rates of vaccination are clearly correlated with the fact that Tennessee has intermittently ranked No.1 for the highest number of COVID positive cases for both adults and children in recent weeks. This is not a statistic I am proud of as a long-time resident. This in turn has resulted in the highest number of hospitalizations and deaths for children to date. Stories like Sophia's are preventable.

### **Purpose Statement**

I am here to share the perspective of children's hospitals as we have navigated the impact of the COVID-19 pandemic. I also appreciate the opportunity to speak more broadly about the role children's hospitals play in advocating for the unique needs of children and adolescents, relative to the impact of the pandemic on their health and overall well-being. My testimony is based upon my expertise in pediatric medicine generally, the work of my colleagues, my experience over the past 18 months leading the Monroe Carell Jr. Children's Hospital at Vanderbilt (hereafter referred to as Children's Hospital) and as one of the leaders in my health system's COVID-19 Command Center.

## Introduction: The Importance of Children's Hospitals in National Healthcare Landscape

Children's hospitals account for only 2% of all the hospitals across the United States, yet we provide nearly all the specialized care for children, adolescents, and increasingly young adults for chronic childhood conditions nationwide. In addition to serving as the safety net of pediatric healthcare for the 80 million children in the United States (20% of the population), most children's hospitals provide the core of the nation's pediatric medical education and research through affiliation with academic medical centers and schools of medicine and nursing.

Children's hospitals in the United States are not-for-profit, community-benefit organizations and Medicaid, not Medicare, is the payor for more than 50% of all patient volumes; thus we have a very different revenue structure than adult-focused hospitals. During the last year, these differences have been highlighted as children's hospitals that have experienced significant financial impact from COVID-19 have often struggled to access federal relief targeted by Medicare-based criteria. Medicaid is a lifeline; this federal-state partnership is the largest source of children's healthcare coverage in the United States. It covers children in every state, from every background. Many of the 40 million children who rely on Medicaid experience medical and social complexities from socio-economic, racial and environmental disparities, and they turn to children's hospitals as resources not only for their healthcare but also to facilitate navigating some of the social complexities that impact health.

#### **COVID-19 Infection in Children**

## Pediatric COVID-19 Symptoms

Children accounted for approximately 15% of COVID-19 positive cases until recent months. Now, children account for up to 30-35% of COVID-19 positive cases. Generally, even with the current Delta variant of the SARS-CoV-2 virus, children have mild, short-term symptoms, like many other viral illnesses: fever, cough, stuffy/runny nose, sore throat, headache and muscle aches. One contributing factor to minimal symptoms in children is a maturational biologic difference in children's lung cells discovered by a multicenter team of researchers led by a neonatologist at Vanderbilt<sup>2</sup>. Unlike in adults, our research has found that the SARS-CoV-2 virus Delta variant interacts in children biologically in the same way as the parent strain of the virus.

## Pediatric Hospitalization due to COVID-19 Infection

Since the beginning of the pandemic, while uncommon, COVID-19 infection in children and adolescents has resulted in hospitalization, with some children becoming critically ill. From March 1, 2020 -August 14, 2021, the cumulative incidence of COVID-19 associated

hospitalizations was 49.7 per 100,000 children and adolescents,<sup>3</sup> with the highest rates of hospitalizations occurring in early September 2021. Children and adolescents who require hospitalization more often have underlying conditions such as Type 1 diabetes, obesity, congenital cardiac and circulatory conditions. While asthma is also a significant predisposing underlying medical condition for infectivity, it was not associated with higher rates of hospitalization<sup>4</sup>. These underlying co-morbidities have remained consistent as we have shifted dominance from the Alpha to Delta viral variants<sup>3</sup>. Of hospitalized children and adolescents, it is estimated that up to 25% require intensive care<sup>3</sup>.

One might ask then, what is different from March 2020 to late summer 2021? Like nearly all viruses, the SARS-CoV-2 virus has mutated. In doing so, it has become more contagious and thus has spread faster, particularly in unvaccinated communities. Nationally, this is most evident in the southeast region<sup>5</sup> where there are lower vaccination rates compared with other regions. At Children's Hospital, we have experienced a definite change in age distribution of symptomatic children testing positive in our system. Prior to July 2021, children ages 6-11 years accounted for 18% of our COVID positive symptomatic children compared to 40% from July to present. In our experience, the Delta variant has infected a higher number of children, but the percentage of children requiring hospitalization is the same. More children are being hospitalized in all areas of the country simply because more children are being infected. While we have observed more symptomatic school-age children from testing data, we continue to see higher percentages of children younger than 5 and older than 12 hospitalized. Of 140 youth hospitalized at Children's Hospital at Vanderbilt between July 1- September 15, 2021, 40% were under 5 and 40% were over 12, and in the latter group, over 90% were unvaccinated.

After COVID-19 Infection in Children: Multi-inflammatory Syndrome in Children

There is another unique nuance to COVID-19 infection in children, an illness known as multi-inflammatory syndrome in children (MIS-C), which was first described and defined in spring 2020 by the Centers for Disease Control and Prevention (CDC)<sup>6</sup>. MIS-C is a syndrome (defined as a grouping of symptoms) that appears to be linked to infection with the SARS-CoV-2 virus and

results in inflammation of several organs, including the heart, lungs, blood vessels, digestive system, and kidneys. In our and others' experience, a secondary wave of seriously ill children requiring hospitalization follows the community peak of acute infection by about 3-6 weeks. The symptoms are initially non-specific, such as fever, but progress dependent upon organ involvement. All children with MIS-C require hospitalization, many need intensive care (up to 25% in our experience), and some have longer hospital stays, most in the range of 5-10 days.

At Children's Hospital, we have a multidisciplinary group that meets regularly to review evolving knowledge about best therapies and follow-up after discharge. This group includes members of eight pediatric specialties and representatives from nursing and our pharmacy. We also have established a multidisciplinary clinic with this same group to follow these patients after their hospitalization. The ability to rapidly deploy interdisciplinary teams in pediatric medicine further demonstrates the unique role children's hospitals play in our country.

Through September 13, 2021, we have admitted 67 children and adolescents with MIS-C, the majority to date clustered earlier this year following the winter COVID-19 surge. Now, we are starting to see more admissions with MIS-C from this Delta surge of infection. Unlike hospitalization with acute COVID-19 infection, in our and others' experiences<sup>7</sup>, this syndrome has a predilection for school-age children and more often affects Black or Hispanic-Latino children who are generally healthy without underlying medical conditions. All our children are followed long-term after discharge in our multidisciplinary clinic with visits at weeks 1 and 4, then at 3, 6 and 12 months. Inflammatory lab testing and echocardiograms are performed at these visits. Fortunately, most of our children and those in other studies<sup>7,8</sup> recover fairly quickly. In our cohort, 79% have normal echocardiograms by 1-week, 93% by 1-month, and 98% by 3 months. Like acute infection, the presentation of MIS-C does not appear to be clinically different between the parent viral strain and the Delta variant.

#### Pediatric Long-Haul Symptoms

The question of 'long-haul' symptoms in children and adolescents is not yet well understood. It does appear that children and adolescents may also experience some element of ongoing symptoms such as fatigue, concentration difficulties, headaches, chest pain and palpitations, muscle weakness and aches<sup>9</sup>, lasting for several months. More research and longitudinal follow-up of all youth who have experienced acute COVID-19 infection, MIS-C and have some element of long-haul symptoms is necessary to understand the full impact of the pandemic on children and youth.

## Impact of COVID-19 Pandemic on Children's Hospitals

I describe the past 18 months of the nation's children's hospitals' pandemic experience as the opposite ends of the bell-shaped curve.

#### Children's Hospitals in 2020

Nationally, 2020 was a very different year for all children's hospitals and pediatric primary care across our country as we experienced the COVID-19 pandemic unfold. While we braced for the potential that SARS-CoV-2's impacts might be felt disproportionately on children early in the pandemic, we thankfully did not have that experience. The maturational biologic difference in children's lung cells previously described combined with public health measures of social distancing, virtual schooling, and more widespread acceptance of masking, resulted in pediatricians and children's hospitals seeing far fewer numbers of children with COVID-19 infection throughout most of 2020 compared to our peers in adult medicine. Furthermore, children did not get sick from the other common ailments of childhood. The common cold, respiratory syncytial virus, influenza and strep throat infections almost completely disappeared.

Overall utilization of healthcare by children decreased dramatically through 2020, resulting in large volume and revenue shortfalls by all children's hospitals and community pediatricians. <sup>10</sup> This analysis showed that overall discharges from children's hospitals decreased by 17%, with

greater decreases in emergency room and primary care visits (35% or more). Over 90% of children's hospitals experienced a negative financial impact in 2020, most in the 5-10% range, regardless of geographic region or metropolitan market. In some instances, this revenue and volume shortfall (for some as high as 25%) resulted in downsizing of specialized pediatric staff such as respiratory therapists and nurses. This downsizing either was intentional due to revenue shortfalls or because of attrition since some chose to become "travelers" for higher financial incentivization (travel staff are healthcare professionals who contract with an agency to provide supplemental staffing for healthcare institutions).

For much of 2020, many children's hospitals, including mine, played a supporting role to our adult hospital community either by sharing staff or offering beds or both, even as we cared for small numbers of children and adolescents with COVID-19 infection or MIS-C. At Children's Hospital at Vanderbilt, we averaged 2-4 COVID positive patients a day in our designated COVID unit through most of 2020 (range 0-15). At VUMC and Children's Hospital, we ensured employment of all staff and thus deployed pediatric staff who were underutilized in their usual duties to other areas either in COVID-19 related roles or as assists to the adult enterprise inpatient units. In November, we offered a unit of Children's Hospital to the adult enterprise for non-COVID, non-critical adult patients to support system bed capacity issues. I know our experience at Vanderbilt is not unique. When neighboring adult hospitals came under immense capacity and staffing strains, many children's hospitals stepped up to help.

## Children's Hospitals in 2021

Following the peak of the third COVID-19 surge in early 2021, coinciding with the onset of COVID-19 vaccination, everyone, including the healthcare industry, began to look forward to returning to our more normal routines. Leaders in children's hospitals and community pediatricians, however, faced considerable uncertainty. Some modeling suggested that we would experience ongoing volume and revenue shortfalls, particularly if children continued to be so healthy-a good problem to face. Common sense might have suggested otherwise, but no one really anticipated the perfect storm of the past six months in pediatric healthcare.

For all children's hospitals, another common pediatric illness has been center stage coming into this fourth COVID-19 surge in infection due to the Delta variant. Respiratory syncytial virus (RSV) is a winter virus that typically infects children from late October to March. As communities loosened public health measures of masking and social distancing, children, particularly the infants and toddlers born from late 2019 through 2020 (and thus who are "germ naïve") began to become sick with RSV and other winter viruses in April 2021, completely and unpredictably off-season. In a matter of weeks, most children's hospitals saw nearly a 50% increase in pediatric emergency department visits and hospital admissions for respiratory illnesses, many requiring intensive care. This respiratory surge has continued through the summer and into early fall, with no real abating in sight. This RSV surge has strained many children's hospitals' capacities, including mine.

Then the Delta COVID-19 surge arrived on top of RSV. In recent weeks, children's hospitals have *tripled* the number of hospitalized children due to COVId-19. At Children's Hospital at Vanderbilt, our peak COVID census was 27 in early September with an average daily COVID census over 20 for three consecutive weeks. At any given time, approximately 25% of these patients have been critically ill. Although we have seen slight improvements in COVID-19 volumes in the past week, we are at the beginning of an anticipated increase in MIS-C volumes.

These overlapping demands on capacity in mine and other children's hospitals may lead to inthe moment decision making about allocation of resources. We recently accepted transfer of a teenager from another children's hospital because of our ability to provide a higher level of care. This young man was obese and had undiagnosed Type 1 diabetes. He had been symptomatic with COVID-19 infection for several days before presenting to his local children's hospital. He became critically ill, requiring ventilator support. He was transferred to us as an alert status for a cardiorespiratory form of support not offered by that children's hospital. We had several children already receiving this support for non-COVID and COVID reasons. We did

accept this patient in transfer but were unable to accept any others for nearly a week because of a resource limitation in our hospital.

Aside from experiencing the financial pain from low volumes in 2020 and the strains of recent high capacity, the pandemic has significantly impacted staffing at children's hospitals. Going into the pandemic, most hospitals nationally, including children's hospitals, were challenged to be fully staffed to desired goals due to broad shortages in nursing and specialized roles such as respiratory therapy. The pandemic caused many staff either to leave healthcare completely or to shift to an employment model with higher financial reimbursement, thereby creating even greater workforce shortages. For children's hospitals, while volumes and associated revenue are in a better place in 2021, the pandemic has placed added burden on the doctors and nurses working on the frontlines. The increased capacity strain, on-going high acuity of patients and chronic staffing challenges are resulting in fatigue, distress and frustration particularly around issues related to unvaccinated status and overall 'burnout.'

## Impact of COVID-19 on Children's Health

Children and their families across the country have faced substantial disruptions to their daily lives due to COVID-19 and its consequences. Intermittent or sustained loss of childcare and virtual schooling placed unprecedented demands on parents, further compounded by new work routines resulting from pandemic safety measures. The Vanderbilt Child Health Poll, launched in 2019 by the Vanderbilt Center for Child Health Policy, aims to understand the concerns and experiences of parents nationwide<sup>11</sup> and in Tennessee. <sup>12</sup> Early in the pandemic, the economic and social consequences were evident. Nationally, between March and June 2020, 1 in 4 parents reported their mental health was worse and 1 in 7 reported their child's behavior was worse.

Of course, safely attending school has been a priority of pediatricians and children's hospitals from the beginning of the pandemic. In the fall of 2020, Tennessee parents reported that only

38% of children were attending in-person at school, 31% virtually only, another 15% learning in a hybrid form, and 15% homeschooling. The poll revealed stark differences in mode of schooling by race. Children in Black families were substantially more likely to be attending only virtual schooling (58%) compared to children in White families (23%). The primary concern of all families with virtual schooling was lack of social interaction with other children (52%) followed closely by lack of 1:1 attention from their child's teachers. And of course, only 20% of parents felt well equipped to assume the role of teacher. This overall situation placed significant stress on mental health well-being of the family unit.

This poll, albeit not a longitudinal study, found that 2 in 5 Tennessee parents reported food insecurity. Some of this insecurity may have resulted from loss of in-person schooling (16%) since school-based food programs are part of many socioeconomically disadvantaged families' routines. In this sample period, nearly 35% of families reporting food insecurity did not receive services from programs like SNAP (Supplemental Nutrition Assistance Program) or the Pandemic Electronic Benefit Transfer Program.

Because of social distancing in place in fall of 2020, many children and youth suspended their sports and group physical activities. Nearly 40% of Tennessee parents felt it was unsafe for young people to participate in group sporting activities. In this survey, concerns were greater among Black parents with nearly 60% concerned about safety compared to 34% of White parents.

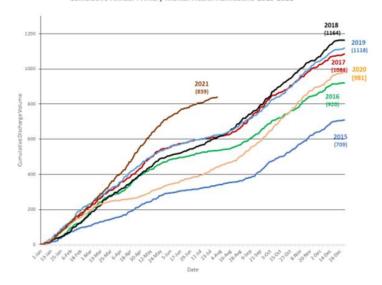
Another negative impact on children resulted from economic instability of the family. In just one year (Fall 2019 to Fall 2020), the number of uninsured children more than doubled - from 4% to 9%, a striking increase, given that our state already traditionally has one of the lowest uninsurance rates among children. In this poll, 20% of families reported either a loss of insurance or a change in insurance due to employment related changes (loss of job or change in job).

This polling presents a snapshot of concerns all culminating in a broad negative impact of the pandemic on the health of our children. Changes in insurance, economic instability compounding existing inequities, food insecurity, decreased physical activity, diminished learning and socialization are all significant concerns for the overall health of our youth. All of these factors are further heightened by the fear of the pandemic, which caused many families to delay healthcare for their children. Most notably this was seen as a delay in well-child visits which are a cornerstone of monitoring children's health from birth through adolescence. Our primary care practices and those in our community had to plead with families to come in for routine care, including other immunizations of childhood. Fortunately, we have recovered, but many children in our community and across the nation are behind on both immunization schedules and routine well-health visits. Additionally, some families delayed seeking care for more severe problems. Early last fall, three children presented to our oncology clinic with more advanced stages of childhood cancer because of fear of COVID-19. Had they been diagnosed earlier they would have had improved outcomes.

## Impact of COVID-19 on the Ongoing Epidemic of Mental Health

Long before the COVID-19 pandemic began, the children's healthcare system across our nation began witnessing a behavioral health epidemic in our youth. Approximately seven or so years ago, children's hospitals across the country, including mine, began to see a new type of patient present to our emergency rooms in increasing numbers: children and adolescents with suicidal ideation and other disruptive behaviors<sup>13</sup>. The graph below illustrates our experience over the past seven years (data tracked by James Gay, MD):





Children's Hospital Association data<sup>14</sup> shows the suicide and self-injury cases (ages 5-17) in the first two quarters of 2021 are 104% higher than the same period in 2016, 43% higher than same period in 2019 and 65.8% higher than 2020. Since children's hospitals are acute care hospitals, not psychiatric hospitals, our options are to hold these patients in our emergency departments or admit them to acute care beds until there is an available acute care psychiatric bed. Long waits for placement exist at essentially every hospital because of a national shortage of inpatient beds committed to children and adolescent psychiatric needs.

At VUMC, I am fortunate that the Vanderbilt Psychiatric Hospital (VPH) is right across the street from Children's Hospital, which has a 26-bed child and adolescent psychiatric unit that runs at nearly 100% occupancy. Because VPH is also the only facility to admit children under 10 with behavioral health diagnoses for over two-thirds of Tennessee, it becomes a referral source through the children's hospital for out-of-region needs. Because of our regional infrastructure,

most patient awaiting acute psychiatric facility placement are admitted to our Children's Hospital.

Over the same weeks I have experienced a high COVID-19 census, I have had almost the same number of patients admitted for behavioral health needs (daily census range 17-29). Children's hospitals are ill-equipped to manage youth with appropriate support during a psychiatric episode; yet most children's hospitals have been compelled to create any number of care models to support this growing population of patients in either our emergency rooms or our hospital beds.

Our nation's pediatric mental health infrastructure is highly fragmented and has not received adequate support for decades. The fact that so many children and adolescents turn to children's hospitals for behavioral health care reflects this fragmentation on the front end: children's hospitals should be the last resort for care of this population and only when there is a medical indication.

The same negative effects of the COVID-19 pandemic on our children's physical health also negatively impact the mental health of our children and youth. The Vanderbilt Child Health Poll<sup>11,12</sup> provided added information from the perspective of families. Notably, parents expressed concern about their children's anxiety, which doubled between 2019 and 2020, with nearly a quarter of those surveyed having concerns. The shift to virtual schooling also disrupted critical access to mental health counseling, which for 35% of those polled was a family's only access to mental health resources. Access to many other community-based mental health resources is limited, fragmented and very difficult for families to navigate. The shift to telehealth is ideal for these services, from schools and other community mental health agencies, but access to the Internet and challenges of navigating telehealth care visits became a barrier for many families. Across many years, studies have shown that children whose mental health needs are inadequately addressed are more likely to experience disciplinary problems, to be more chronically absent from school, and to develop other behaviors that negatively

impact physical health, thereby demonstrating the important link between physical and mental health in overall well-being.

#### Summary

The COVID-19 pandemic continues, with uncertainty of either a true end or transition to a manageable disease, not unlike seasonal influenza or RSV for children. We know from our journey to date, that the importance of public health measures stem the spread of infection, including masking. The generally accepted model for returning children to school is masking, regular testing, social distancing when feasible, and vaccination when eligible. Vaccinations are a mainstay of child and adolescent health. Some childhood diseases have been eradicated because of immunizations (e.g. polio, measles). Others have been tempered (e.g. influenza, human papilloma virus). The ability to vaccinate children of all ages against COVID-19 infection is a key next step in moving this pandemic to a chapter in history.

Returning to the story from the start of my testimony. The importance of promoting acceptance and safety of the COVID-19 vaccines currently accessible to the citizens of our nation is essential. Childhood immunization against COVID-19 is also essential. Young Sophia might not have become infected and more than likely would be living with her parents today had everyone been vaccinated. Pediatricians are the trusted source of truth for most families when it comes to children and adolescent healthcare. Pediatricians look forward to being able to offer COVID-19 vaccines to younger children in coming weeks and months. But they will have an uphill journey to convince families of both the safety and importance of these vaccines if we can't get beyond the misinformation and the polarized messaging in our communities.

Congress has provided timely and significant bipartisan support to healthcare providers serving on the front lines of the COVID-19 pandemic through a series of large legislative measures.

Without this support, hospitals like Monroe Carell Jr. Children's Hospital at Vanderbilt that I lead would be in a far worse position today as we grapple with the current surge of the delta

variant simultaneous to high caseloads of seasonal viral infections like RSV and behavioral health patients.

Your support has included over \$186 billion for the Provider Relief Fund, which has helped hospitals, physician practices and other providers offset lost revenue and cover unreimbursed COVID-19 related expenses. Congress has provided billions in funding to accelerate COVID-19 research—including studies and clinical trials at Vanderbilt. You have helped drive the unprecedented pace of medical countermeasure development and provided funding for a range of public health activities inclusive of the ongoing vaccines distribution efforts. Finally, and of special note, I am grateful for the concern you have shown in advancing policies to break down coverage, access, and financial barriers individuals or their families might have otherwise faced in seeking testing and care for a COVID-19 infection.

#### **Policy Recommendations**

Unfortunately, as the facts of my testimony outline, unmet needs remain in our campaign to move past this virus. My colleagues at the Children's Hospital Association and I believe there are several concrete steps Congress should take to help children at this juncture, including through consideration of legislation put forward by members of the Energy and Commerce Committee. I commend for your consideration the following:

H.R. 5131, the Pediatric Access to Critical Healthcare (or PATCH) Act, would provide
grants to children's hospitals and other pediatric providers to make critical investments
in the nation's pediatric care infrastructure, including ICU capacity and emergency
preparedness. A dedicated pediatric infrastructure account would be an excellent
complement to efforts explored elsewhere by Congress and this Committee to revive
Hill-Burton hospital infrastructure funding that is likely to focus on adult care facilities.

- H.R. 4943, the Children's Mental Health Infrastructure Act, would provide funding for grants to children's hospitals and other providers to expand pediatric mental health services, an area of enormous need discussed in my testimony.
- H.R. 4944, the Helping Kids Cope Act, would support grants for provider-led community-based initiatives that can improve behavioral health care integration and coordination.
   Importantly, the bill would also provide funding to support workforce training for a range of pediatric behavioral health professionals, both physicians and non-MD professionals.

I would be remiss if I did not also note the leading role that existing federal programs play in supporting the pediatric healthcare workforce. As members of this committee are aware, the Children's Hospital Graduate Medical Education (CHGME) program is a dedicated source of discretionary dollars that support residency training programs at freestanding children's hospitals, which are ill-served by the Medicare GME program because of the dearth of Medicare funding to these facilities. I recommend that you increase the CHGME program, which would greatly help address workforce shortages in pediatric specialty and subspeciality care areas.

While CHGME targets a specific need at freestanding children's hospitals, many other pediatric residency and fellowship programs are supported by the larger Medicare GME program, such as those programs run at general teaching hospitals and children's hospitals that are part of a larger system. Despite a modest expansion of Medicare-funded slots authorized by Congress in 2020, the Medicare GME program has not kept pace with the nation's growing provider shortage projections in both primary and specialty care. Thus, in addition to expanding CHGME, Congress also should implement meaningful expansion of the number of Medicarefunded GME residency slots. H.R. 2256, the Medicare Resident Physician Shortage Reduction Act, addresses this issue.

Both CHGME and Medicare GME are critical components to the future provider workforce in pediatrics for children's hospitals.

Thank you for the opportunity to support these efforts and your consideration for the children in our nation. To quote a colleague, Dr. Thomas Tsai, professor of health policy at Harvard University, "What really protects children are the interventions directed at the rest of society." <sup>15</sup> Children like Sophia need adults to protect them.

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Ms. DEGETTE. Thank you so much, Dr. Rush.

Dr. Evans, I'm now pleased to recognize you for 5 minutes for an opening statement.

## STATEMENT OF ARTHUR C. EVANS, JR., Ph.D.

Dr. Evans. Chair DeGette, Chairman Pallone, Ranking Member Griffith, Ranking Member McMorris Rodgers, and members of the subcommittee, thank you for this opportunity to testify today. I'm Dr. Arthur C. Evans, CEO of the American Psychological Association.

The APA is the largest scientific and professional organization representing psychology in the U.S., with over 122,000 clinicians, researchers, consultants, and students as its members and affiliates. APA appreciates the subcommittee's focus on the mental health of the Nation's youth.

Children and adolescents have been especially affected by the COVID-19 pandemic, experiencing higher rates of stress, anxiety, and fear. Social isolation, financial uncertainty, and disrupted routines place considerable stress on children and their families. And we remain especially concerned about increases in the rates of suicide attempts and other forms of self-harm among children and youth, particularly among those within communities of color.

The reason for these phenomena are manifold, and many of these

concerns were already present prior to the pandemic.

Psychological research tells us that the mental health of children is frequently tied to the health of their surroundings, such as their communities, schools, and homes. And if traumatic events are occurring in these settings, they almost always have a downstream impact on children's well-being.

Psychological science also shows that the consequences of untreated mental health needs on the overall trajectory of children's lives. This can include a greater likelihood of difficulties with learning, addiction to substances, learning, lower employment prospects, and involvement with the criminal justice system.

This concern is amplified for individuals from underserved communities and communities of color who have long struggled with the social determinants that lead to behavioral health conditions and inadequate access to behavioral health services.

There is no one-size-fits-all solution to meeting all of the mental health needs among children, but the science is clear in several areas

One key area is early detection and intervention. As children return to school, comprehensive, school-based mental health services, such as those provided by school psychologists, are critical to overcoming learning loss and addressing behavioral health issues effectively.

We must also invest in opportunities to foster positive school climates. This includes integrating evidence-based and culturally competent social and emotional learning programs, and promoting trauma-informed approaches to teaching and student well-being.

Outside of schools, we must ensure that children and families have access to high-quality mental health services, including telehealth. We need to invest in more behavioral health research to support early intervention. We also need to equip educators, families, and communities to recognize early signs of mental health and emotional distress in children.

While APA appreciates Congress' significant investments in mental health during the COVID-19 pandemic, part of the problem is that such funding is temporary, which often inhibits the ability of States and school systems to make long-term investments in their mental health workforce and infrastructure.

New investments must be made with the understanding that a long-term commitment is needed. We must avoid perpetuating a false choice between children's education and mental well-being and their physical health and safety. We need both.

Ideally, all children should be in a physical classroom with their teachers and peers. We can and should be doing everything possible to reopen schools safely, adhering to proven public health measures while providing virtual options if they become necessary.

Federal, State, and local governments should be working in concert to ensure that all children continue to have access to equitable education and support services, while staying mentally and physically healthy.

I applaud the subcommittee for convening today's hearing. The challenges we currently face provide us with an extraordinary opportunity to reimagine how we address the behavioral health of all of our citizens, including our youngest.

Thank you, and I look forward to answering your questions. [The prepared statement of Dr. Evans follows:]



## Written Testimony of Arthur C. Evans, Jr., PhD Chief Executive Officer American Psychological Association

Putting Kids First: Addressing COVID-19's Impacts on Children

Before the U.S. House of Representatives House Committee on Energy and Committee Subcommittee on Oversight and Investigations

September 22, 2021

Chairwoman DeGette, Ranking Member Griffith, and members of the Oversight and Investigations Subcommittee, thank you for the opportunity to testify today on the vital topic of the COVID-19 pandemic's impact on the behavioral health of our nation's children and adolescents. I am Dr. Arthur C. Evans, Jr., Chief Executive Officer and Executive Vice President of the American Psychological Association (APA). APA is the nation's largest scientific and professional organization representing the discipline and profession of psychology. APA has more than 122,000 members and affiliates who are clinicians, researchers, educators, consultants, and students. Through the application of psychological science and practice, our association's mission is to have a positive impact on critical societal issues.

APA appreciates the Subcommittee's interest in and attention to child and adolescent behavioral health, which comes at an especially critical time. With the nation struggling to move beyond the COVID-19 pandemic, many children and their families continue to experience mental health impacts from the pandemic, such as increased stress from loss of income and trauma from the loss of a loved one, as well as social disruptions. Many of our nation's youth—particularly

those who are too young to receive the vaccine, those who are immunocompromised due to a disability or other medical condition, and those from rural communities and communities of color—remain at heightened risk of contracting COVID-19 or experiencing severe illness, which compounds the impact of both the disease itself and its effects on mental health.

The heightened vulnerability of children to the mental health after-effects of a crisis is not a new phenomenon. Data gathered from past public health crises and natural disasters, such as the outbreak of AIDS<sup>1</sup> or the aftermath of a hurricane<sup>2</sup>, consistently show that children experience more frequent and more intense levels of stress and anxiety post-crisis. These issues are exacerbated by our current behavioral health system, which relies largely on an "acute care" or "crisis care" model that waits for early symptoms of unmet behavioral health needs to escalate to a point of crisis and reach a diagnostic threshold before treatment is begun.

A population health perspective is central to moving the nation's behavioral health system beyond the current pandemic. Longstanding systemic health and social inequities place people of color and other marginalized communities at increased risk of contracting COVID-19 or experiencing severe illness.<sup>3</sup> While Congress's historic investments in mental health and substance use treatment during COVID-19, as well as expanded access to new modalities of treatment such as telehealth, have been essential to meeting the increased demand for such services, the data show that continued investment is still necessary. For example, while many schools are eager to increase the mental health services they provide, the temporary nature of much of the pandemic-related funding limits their ability to do so on the long-term basis that is needed. Considering the many

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<sup>3</sup> Louis-Jean, J., Cenat, K., Njoku, C. V., Angelo, J., & Sanon, D. (2020). Coronavirus (COVID-19) and Racial Disparities: a Perspective Analysis. Journal of Racial and Ethnic Health Disparities, 7(6), 1039–1045. <a href="https://doi.org/10.1007/s40615-020-">https://doi.org/10.1007/s40615-020-</a> <u>00879-4</u>

competing priorities that schools have, this budget uncertainty is a barrier for some school districts, especially those located in low-resource areas, to creating permanent positions for a full complement of school-based mental health providers, as well as hiring more teachers and providing necessary professional development for educators.

Similarly, many treatment systems hesitate to make necessary capital investments, especially as the emergence of the Delta variant has upended many initial plans on how federal relief funding would be spent. As state and local leaders plan for the future, ensuring a steady stream of funding from the federal government is critical. If we are to systematically reimagine the way we provide both physical and mental health care, our response cannot just be COVID-centric but must be sustainable, equitable, and forward-thinking.

My testimony today will outline evidence-based tools informed by psychological science that members of this Subcommittee can utilize in providing oversight of the federal response to COVID's impact on childhood and adolescent health, as well as the stewardship of taxpayer dollars. These include: (1) understanding the unique behavioral health challenges facing children and adolescents; (2) using a population health approach to ensure an effective and efficient national strategy for the behaviorial health needs of children and adolescents; (3) connecting physical and behavioral health with evidence-based interventions; and (4) boosting school-based mental health services.

## Unique Mental and Behavioral Health Challenges of Children and Adolescents

The COVID-19 pandemic is calling public and congressional attention to the large unmet behavioral health needs of children and adolescents that pre-dated COVID-19 and are being exacerbated by the pandemic. There exists a persistent gap between children who require mental health treatment and those who receive it.<sup>4</sup> Tragically, suicide rates among children aged 10 and older have climbed significantly each year since 2007, making suicide the second most common cause of death among adolescents before the pandemic.<sup>5</sup>

A growing body of evidence demonstrates that the mental health of children and youth continues to deteriorate in the current environment, including among those who did not previously exhibit symptoms of a behavioral health disorder. Social isolation, financial uncertainty, and disrupted routines place considerable stress on children and their families, significantly affecting their mental health and well-being, as demonstrated by disproportionate increases in the rates of suicide attempts and other forms of self-harm amongst children and youth—particularly among those from communities of color.

Minority stress and adverse experiences influence behavioral health within marginalized populations, such as those defined by gender, race and ethnicity, gender identity and sexual orientation, immigration status, disability, or chronic medical conditions. Behavioral health challenges in children and adolescents vary significantly by race and ethnicity, with higher rates of moderate and severe challenges among Hispanic and African Americans than among non-Hispanic Whites.<sup>7</sup> In addition to the behavioral health burden experienced by racial/ethnic minority

<sup>&</sup>lt;sup>4</sup> Centers for Disease Control and Prevention. (August 21, 2020). Youth Risk Behavior Surveillance. Retrieved from: <a href="https://www.cdc.gov/mmwr/volumes/69/su/pdf/s/su6901-H.pdf">https://www.cdc.gov/mmwr/volumes/69/su/pdf/s/su6901-H.pdf</a>. Substance Abuse and Mental Health Services Administration (September 2020), Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, <a href="https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFR1PDFW070120.pdf">https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFR1PDFW070120.pdf</a>

<sup>&</sup>lt;sup>5</sup> Centers for Disease Control and Prevention. (2020). National Vital Statistics Reports. State Suicide Rates Among Adolescents and Young Adults Aged 10–24: United States, 2000–2018, <a href="https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-11-508.pdf">https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-11-508.pdf</a>. Cebe RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1675–1680. DOI: <a href="http://dx.doi.org/10.15585/mmwr.mm6945a3external.icon">https://dx.doi.org/10.15585/mmwr.mm6945a3external.icon</a>; St. George, Donna & Strauss, V. (January 21, 2021). Partly hidden by isolation, many of the nation's school children struggle with mental health. The Washington Post. Retrieved from: <a href="https://www.washingtonpost.com/local/education/student-mental-health-pandemic/2021/01/21/3d377bea-3f30-11eb-8d88-395dedaaa036">https://www.washingtonpost.com/local/education/student-mental-health-pandemic/2021/01/21/3d377bea-3f30-11eb-8d88-395dedaaa036</a> story.html.

pandemic/2021/01/21/3d377bea-3f30-11eb-8db8-395dedaaa036\_story.html.

Algria, M., Green, J. G., McLaughlin, K. A., & Loder, S. (2015). Disparities in child and adolescent mental health and mental health services in the US. William T. Grant Foundation. https://wtgrantfoundation.org/library/uploads/2015/09/Disparities-in-Child-and-Adolescent-Mental-Health.pdf

children and adolescents, significant barriers exist in their access to and utilization of behavioral health services. Behavioral health disparities. Behavioral health disparities can occur for children with developmental and physical disabilities and chronic medical conditions due to discrimination, attitudinal and physical barriers, abuse and neglect, and lack of accessible and disability-sensitive services. Description

The Centers for Disease Control and Prevention (CDC) data likewise indicate that between April and October of 2020, hospitals experienced a 24% increase in the proportion of mental health-related emergency department (ED) visits by children ages 5 to 11, as well as a 31% increase for adolescents ages 12 to 17. In a follow-up study, CDC found that, beginning in May 2020, ED visits for suicide attempts began to increase among adolescents ages 12 to 17, with visits 39% higher than during the same period in 2019. With the ongoing spread of the Delta variant, these trends continue to stress our already-overworked systems to aid youth in crisis. A growing number of children are "boarded" in hospital EDs awaiting treatment because there are no alternative placement options. Exacerbated by shortages of mental health professionals across disciplines, there is insufficient capacity to provide the level of care needed and to support the more effective integration of services across the continuum.

<sup>&</sup>lt;sup>8</sup> Austin, A., & Wagner, E. F. (2010). Treatment attrition among racial and ethnic minority youth. *Journal of Social Work Practice in the Addictions*, 10, 63-80.

<sup>&</sup>lt;sup>9</sup> Cohn, T. J., & Leake, V. S. (2012). Affective distress among adolescents who endorse same-sex sexual attraction: Urban versus rural differences and the role of protective factors. *Journal of Gay & Lesbian Mental Health*, 16(4). 291-305; Eisenberg, M. E., & Resnick, M. D. (2006). Suicidality among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors. *Journal of Adolescent Health*, 39(5), 662-668; Mustanski, B., Garofalo, R., & Emerson, E. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health*, 100(12), 2426-2432.

<sup>&</sup>lt;sup>10</sup> American Psychological Association. (2011). Task Force on Guidelines for Assessment and Treatment of Persons with Disabilities. Guidelines for Assessment of and Interventions with Persons with Disabilities. http://www.ana.org/pii/disability/resources/assessment-disabilities.aspx.

http://www.apa.org/pi/disabilitv/resources/assessment-disabilities.aspx.

11 Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019—May 2021. MMWR Morb Mortal Wkl Rep 2021; 70:888–894. https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s\_cid=mm7024e1\_w; Science Friday (August 20, 2021), Pandemic Unveils Growing Suicide Crisis For Communities of Color, https://www.sciencefriday.com/segments/suicide-crisis-communities-of-color/

Many of these phenomena are attributable to the fact that our traditional "acute care" model of mental health treatment simply does not work for children and adolescents. First, the mental health of a child is frequently tied to surrounding environmental structures and systems as well as familial dynamics—such as parents' work demands, the health of the home environment, and the supportiveness of the school environment—that are often outside of the child's control.

Second, even relatively small investments in children's mental health early in their lives can have clear positive long-term effects. Most common disorders, including those with the greatest morbidity, have onset in childhood or adolescence. Childhood and adolescence provide critical periods for prevention, early detection, and intervention to promote lifetime wellbeing. Rather than activate resources only when a child experiences a crisis, which may inhibit the long-term effectiveness of treatment, our behavioral health system must focus resources earlier in a child's life and address the factors that led to the child experiencing a crisis in the first place.

# **Applying a Population Health Approach**

The COVID-19 pandemic and the societal issues it has exacerbated clearly illustrate the limitations of the traditional mental health treatment model for children and adolescents. Epidemiological data suggests that at least 25% of the U.S. population has a diagnosable mental health disorder or severe mental illness and may receive at least some degree of treatment. The remaining 75% of the population who have not received a formal mental health diagnosis—but who may be experiencing subclinical or more minor symptoms of behavioral health needs—are

 <sup>&</sup>lt;sup>12</sup> Kessler, R.C. & Wang, P.S. (2008). The descriptive epidemiology of commonly occurring mental disorders in the United States. *Annual Review of Public Health*, 29, 115-129.
 <sup>13</sup> Substance Abuse and Mental Health Services Administration (2020). Key substance use and mental health indicators in the

<sup>&</sup>lt;sup>13</sup> Substance Abuse and Mental Health Services Administration (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Centers for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

virtually ignored by our behavioral health care system until they reach a point of crisis. (See Figure 1: Current U.S. Treatment Approach).

Data reveal that large proportions of the population experienced significant and persistent distress during the pandemic, including disturbances Figure 1: Current U.S. Treatment Approach



in sleep and eating, significant weight gain and increased substance use<sup>14</sup>. The CDC reports that this proportion of the population experiencing symptoms of depression and anxiety is now three to four times than the rate before the pandemic. 15 Children and adolescents are not immune to this phenomenon, and ignoring children because they fall below an acute crisis threshold portends many missed opportunities for early intervention and prevention. In addition to their obvious wasting of human potential, these missed opportunities pose a real fiscal cost to society as a  $whole.^{16} \\$ 

Improving the health of the entire population requires an expansion of where we see interventions occurring across the entire continuum of behavioral health needs and how they are carried out. In contrast to the 25%/75% split described above, a population health perspective involves a multi-tiered approach, including: 1) effective and efficient clinical care for those experiencing behavioral health disorders; 2) mitigating the impact of risk factors for those individuals who have elevated risk for behavioral health disorders and intervening early if those

<sup>&</sup>lt;sup>14</sup> American Psychological Association. (2021). Stress in America: One Year Later, A New Wave of Pandemic Health Concerns.

Washington, DC. https://www.apa.org/news/press/releases/stress/2021/sia-pandemic-report.pdf

15 Vahratian, A., Blumberg, S.J., Terlizzi, E.P., Schiller, J.S. (2021). Symptoms of anxiety or depressive disorder and use of mental health care among adults during the COVID-19 pandemic: United States, August 2020-February 2021. MMWR, 70(13),

<sup>490.494.

&</sup>lt;sup>16</sup> Conduct Problems Prevention Research Group. (2011). The effects of the Fast Track preventive intervention on the development of conduct disorder across childhood. Child Development, 82(1), 331-345.

efforts are not successful; and 3) providing tools and resources that promote wellness for those who are relatively healthy.<sup>17</sup> (See Figure 2, Population Health Approach).

This perspective includes moving behavioral health beyond specialists in specific clinical settings and beyond healthcare itself, into the places where people live, work and play; away from a sole focus on treatment towards greater reliance on preventative "upstream" interventions; and into



Figure 2: Population Health Approach

communities that – when properly empowered – play a pivotal role in shaping solutions to their unique challenges.

In the next 12 months, the physical and mental health of our nation's youth will depend heavily on maximizing vaccine uptake and engagement in other COVID-19 preventative behaviors among youth and their families. To address these needs, CDC awarded APA a \$2 million grant supplement to engage in a multitiered partnership that leverages psychological science to address COVID-19 priorities, including supporting informed vaccine decision-making and combatting misinformation. This partnership leverages behavioral science to address the largest public health crisis in a century, and the application of behavioral science will significantly advance several of CDC's key priorities. In addition, APA is also partnering with CDC to produce educational materials for teachers on pandemic-related topics of resilience, working with communities, teaching and learning issues, school-family engagement, educational disparities, and the science of persuasion, as well as mental health-related topics, such as grief and trauma.

<sup>&</sup>lt;sup>17</sup> Evans AC, Bufka LF. The Critical Need for a Population Health Approach: Addressing the Nation's Behavioral Health During the COVID-19 Pandemic and Beyond. Prev Chronic Dis 2020; 17:200261. DOI: <a href="http://dx.doi.org/10.5888/pcd17.200261external.icon">http://dx.doi.org/10.5888/pcd17.200261external.icon</a>

## Connecting Physical and Behavioral Health with Evidence-Based Interventions

Physical and behavioral health are inextricably connected, and efforts to address physical health needs without adequate attention to co-occurring behavioral health conditions are less likely to be effective. This assertion is supported by three bodies of literature. First, there is a high level of comorbidity between physical and mental health disorders, with ample evidence illustrating that the presence of a mental health disorder is a significant risk factor for the onset of a physical health disorder, and vice versa. <sup>18</sup>

Second, compromised behavioral health is a significant determinant of overall health behavior and health decision-making, such as adherence to medical regimens. Emerging evidence suggests that psychological factors also substantially explain an individual's degree of compliance with COVID-19 mitigation behavior such as social distancing and vaccination. Third, psychological factors—including, but not limited to, social stress, poor sleep quality, and interpersonal conflict—substantially influence the immune system, with potentially dire physical health outcomes, such as inflammatory disease, viral infection, and health morbidity and mortality. 19, 20 Attempts to improve children's physical health outcomes must therefore attend to their co-occurring behavioral health needs to maximize the likelihood of a successful intervention.

As children return to school environments with elevated stress levels due to the pandemic, parents and school systems alike can utilize strategies based in psychological science to help manage that stress and simultaneously address students' physical and mental health needs, whether students continue learning in a virtual environment or return to campus-based education. For

<sup>&</sup>lt;sup>18</sup> Australian Institute of Health and Welfare, 2007 (2012). Comorbidity of mental disorders and physical conditions, Cat. no. PHE 155. Canberra: AIHW, https://www.aihw.gov.au/getmedia/05a9c315-7576-4c3f-aa2a9cbc14964c3e/10953.pdf
<sup>19</sup> Cohen, S. (2021). Psychosocial vulnerabilities to upper respiratory infectious illness: Implications for susceptibility to coronavirus disease 2019 (COVID-19). Perspectives on Psychological Science, 16(1), 161–174.

https://doi.org/10.1177/1745691620942516

Slavich, G. M., & Cole, S. W. (2013). The emerging field of human social genomics. Clinical Psychological Science, 1(3), 331–348. https://doi.org/10.1177/2167702613478594

example, school systems can train educators and support staff in using evidence-based, culturally appropriate trauma-informed practices for teaching and learning, which recognize adverse childhood experiences (ACEs) as well as their impact on a child's health and development. These are often deployed as trauma-informed approaches to managing student behavior, as well as mental health screenings and follow-up protocols administered by qualified mental health personnel.

Fortunately, members of this subcommittee have supported additional funds for research programs when it appeared the need was greatest. The 21<sup>st</sup> Century Cures legislation, for example, included a significant boost in funding for National Institutes of Health (NIH) research, and we anticipate the upcoming CURES 2.0 bill drafted under the leadership of Chair DeGette will shape the new NIH Advanced Research Projects Agency for Health (ARPA-H) agency. Research on children's mental health is urgently needed as we see how the pandemic has uniquely and disproportionately affected children. Scientific research is our best tool for improving public health and educational systems to help children overcome the challenges of the pandemic, and preparedness for subsequent crises.

Regrettably, funding for mental health research has not seen the same boost that other areas of science have enjoyed. While the National Institute of Mental Health and National Institute of Child Health and Human Development are currently funding an initiative on COVID-related impacts of school closing and lockdown issues, a larger effort is needed. We encourage Committee members to support funds to NIH specifically for research on mental health and substance use. H.R.1716, the COVID Mental Health Research Act, could advance research on topics including: (1) Population health research to develop primary prevention programs in emotional regulation, social relationships, mindfulness, and scientific literacy to misinformation; (2) Research on large

scale, electronic-based delivery of evidence based psychosocial treatment for youth; (3) Suicide prevention research; and (4) Training support, especially for more scientists of color.

## **Emphasizing the Value of School-Based Mental Health Services**

Students across the nation spent the last year grappling with the fallout of a global pandemic and a national reckoning on race. <sup>21</sup> Parents report higher-than-normal levels of behavioral issues in their young children, <sup>22</sup> and teens are experiencing elevated stress, anxiety, and symptoms of depression. <sup>23</sup> Many school-age children have had to cope with social isolation, loneliness, and struggles with family financial insecurity. Others have faced unthinkable loss and severe trauma. <sup>24</sup> Many youths are turning to social media to retain a sense of connection to their peers and communities. While the current data suggest that the length of time children participate on social media may not be associated with deleterious outcomes, emerging research suggests that the capacity to influence youth towards maladaptive behavior is often greater online, and some patterns of social media use of have been associated with engagement in unhealthy behaviors, such as anorexia or self-cutting, and mental health challenges, like depression.

The impact of the pandemic on children and youth from traditionally underserved populations, including communities of color, appears to be more severe.<sup>25</sup> Even before the

<sup>&</sup>lt;sup>21</sup> Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020.</p>
MMWR Morb Mortal Wkly Rep 2020; 69:1675–1680. DOI: <a href="http://dx.doi.org/10.15585/mnwr.mm6945a3external.icon;">https://dx.doi.org/10.15585/mnwr.mm6945a3external.icon;</a> Loades, M. E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A., Linney, C., McManus, M. N., Borwick, C., & Crawley, E. (2020). Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID-19. Journal of the American Academy of Child and Adolescent Psychiatry, 59(11), 1218–1239.e3. <a href="https://doi.org/10.1016/j.jaac.2020.05.009">https://doi.org/10.1016/j.jaac.2020.05.009</a>.

<sup>&</sup>lt;sup>22</sup> Barnett, W.S., & Jung, K. (2021). Seven Impacts of the Pandemic on Young Children and their Parents: Initial Findings from NIEER's December 2020 Preschool Learning Activities Survey. New Brunswick, NJ: National Institute for Early Education Research. Retrieved from: <a href="https://nieer.org/wp-">https://nieer.org/wp-</a>

content/uploads/2021/02/NIEER Seven Impacts of the Pandemic on Young Children and their Parents.pdf.

<sup>23</sup> American Psychological Association, (2020). Stress in America 2020: Stress in the Time of COVID-19. Retrieved from https://www.ang.org/news/press/repess/stress/2020/freports-colorer

https://www.apa.org/news/press/releases/stress/2020/report-october.

24 Kidman R, Margolis R, Smith-Greenaway E, Verdery AM. Estimates and Projections of COVID-19 and Parental Death in the US. JAMA Pediatr. Published online April 05, 2021. doi:10.1001/jamapediatrics.2021.0161.

<sup>&</sup>lt;sup>25</sup> Government Accountability Office. (2020). Distance Learning: Challenges Providing Services to K-12 English Learners and Students with Disabilities during COVID-19. Retrieved from: <a href="https://www.gao.gov/products/GAO-21-43">https://www.gao.gov/products/GAO-21-43</a>; Harvard Medical

pandemic, these children were at a higher risk of depression and substance misuse, while also having less access to behavioral health services.<sup>26</sup>

These are the experiences that students will bring with them as they return to in-person instruction, which will affect their ability to meaningfully engage in learning.<sup>27</sup> Untreated mental health issues make it more difficult for students to learn and are highly correlated with chronic absenteeism, school failure, and school dropout, which can lead to possible underemployment, financial instability, or involvement with the juvenile and/or criminal justice system.<sup>28</sup> This spring, the Department of Education included APA recommendations on addressing the social, emotional, mental health, and academic impacts of the pandemic on students, educators, and staff in its COVID-19 reopening guidelines.<sup>29</sup> APA further recommends that Congress, through its oversight capacity, encourage stronger collaboration and partnerships between the Department of Education, the Department of Health and Human Services, and the Substance Abuse and Mental Health Services Administration. This must extend to any data collection efforts as it pertains to the impacts of COVID-19 on children and adolescents' behavioral health and emotional well-being.

In many communities, schools are an essential—and often the only—source of meeting the physical and mental health needs of students and families. Many school districts leverage Medicaid funds to stretch scarce resources and create school-based mental health programs. However,

School Center for Primary Care. (August 2020). LGBTQ Youth Face Unique Challenges Amidst COVID-19. Retrieved from: <a href="http://info.primarycare.hms.harvard.edu/blog/lgbtq-vouth-challenges-covid-19">http://info.primarycare.hms.harvard.edu/blog/lgbtq-vouth-challenges-covid-19</a>.

<sup>26</sup> Agency for Healthcare Research and Quality. (2017). 2017 National Healthcare Quality and Disparities Report. Retrieved

<sup>&</sup>lt;sup>24</sup> Agency for Heatthcare Research and Quanty. (2017). 2017 National Heatthcare Quanty and Disparities Report. Retrieved from: <a href="https://www.ahrq.gov/research/findings/nhqrdr/nhqdr17/index.html">https://www.ahrq.gov/research/findings/nhqrdr/nhqdr17/index.html</a>; Irwin, C. E., Jr, Adams, S. H., Park, M. J., & Newacheck, P. W. (2009). Preventive care for adolescents: Few get visits and fewer get services. Pediatrics, 123(4), e565-72. doi:10.1542/peds.2008-2601.

<sup>&</sup>lt;sup>27</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, CDC-Kaiser ACE Study, H.R. Rep. (June 4, 2016). Retrieved from https://www.cdc.org/vii.juper.empressip.org/esert/pu/pleput/pii.

https://www.cdc.gov/violenceprevention/acestudy/about.html.

<sup>28</sup> Sacks, V., & Murphey, D. (2018). The prevalence of adverse childhood experiences, nationally, by state, and by race/ethnicity Bethesda, MD: Child Trends; National Collaborative on Education and Health. (2015). Brief on chronic absenteeism and school health. Chicago, IL: Healthy Schools Campaign.

<sup>&</sup>lt;sup>29</sup> U.S. Department of Education. (April 2021). COVID-19 Handbook, Volume 2: Roadmap to Reopening Safely and Meeting All Students' Needs. Retrieved from: https://www2.ed.gov/documents/coronavirus/reopening-2.pdf.

shortages of school-based behavioral health professionals continue to persist. While the recommended ratio of school psychologists is 1 for every 500 students, the current national ratio is approximately 1 school psychologist for every 1,400 students. Other school-based mental health professionals, such as school counselors and social workers, face similar shortages. Schools—especially those that are under-resourced and serve high numbers of low-income students and students of color—must receive more support to address these needs by increasing and retaining an adequate workforce of diverse, culturally competent school-based mental health professionals to provide accessible services.

Accordingly, APA recommends enacting the Increasing Access to Mental Health in Schools Act (H.R. 3572), which supports partnerships between institutions of higher education and local education agencies to increase the number of school-based mental health professionals, as well as the Mental Health Professionals Workforce Shortage Loan Repayment Act (H.R. 3150), which authorizes a student loan repayment program to increase mental and behavioral health professionals, including in schools and community health centers. In addition, we urge Congress to fund an additional \$1 billion for school-based mental health providers, as included in the House-passed FY 2022 Labor-HHS-Education Appropriations bill.

As educators, administrators, and policymakers work to mitigate the impacts of unprecedented levels of learning loss, <sup>31</sup> improving the behavioral health and emotional well-being of all students is a critical component of achieving that goal. <sup>32</sup> This includes instituting

<sup>&</sup>lt;sup>30</sup> National Association of School Psychologists. (2017). Shortages in school psychology: Challenges to meeting the growing needs of U.S. students and schools. Retrieved from: <a href="https://www.nasponline.org/resources-and-publications/resources-and-publications/resources-in-school-psychology/shortages-in-school-psychology-shortages

podcasts/school-psychology/shortages-in-school-psychology-resource-guide.

31 McKinsey & Company. (December 8, 2020). COVID-19 and learning loss—disparities grow and students need help. Retrieved from: https://www.mckinsey.com/industries/public-and-social-sector/our-insights/covid-19-and-learning-loss-disparities-grow-and-students-need-help.

and-students-need-help.

32 American Psychological Association. (2020). Recommendations on Starting School During the COVID-19 Pandemic Retrieved from: https://www.apa.org/ed/schools/teaching-learning/recommendations-starting-school-covid-19.pdf.

comprehensive behavioral health systems in schools to reduce the frequency and severity of mental health and substance use disorders among students. This holistic approach provides a full complement of supports and services that establish multi-tier interventions, and promote positive school climates, social and emotional learning practices, and overall mental health and well-being. They are built on collaborations between students, families, community health partners, school districts, and school professionals, such as administrators, educators, and specialized instructional support personnel, including school psychologists.

Comprehensive school-based behavioral health services are critical to effective teaching and learning. Integrating evidence-based, culturally competent social and emotional learning programs and trauma-informed approaches to teaching and student well-being, throughout all aspects of the school ecosystem, help foster positive school climates and develop skills such as motivation and engagement, problem-solving, emotional intelligence, resilience, agency, and relationship building.<sup>33</sup> An interactive approach to academic achievement, instruction, and social and emotional learning will help ensure that all children, including some of the most vulnerable, receive a more equitable and higher quality public education.<sup>34</sup>

Such universal programs also help address student behavioral challenges by implementing positive, non-punitive, restorative measures rather than retributive and exclusionary practices. In the aftermath of a crisis, it is not unusual to see students exhibiting what would typically be considered behavioral concerns. Data show that increased school-based mental health services, along with evidence-based training and ongoing professional development for educators on social

<sup>&</sup>lt;sup>33</sup> American Psychological Association, Coalition for Psychology in Schools and Education. (2015). Top 20 principles from psychology for preK–12 teaching and learning. Retrieved from https://www.apa.org/ed/schools/teaching-learning/top-twentyprinciples.pdf.

paylates by the principles pdf.

34 American Psychological Association. (2020). Dynamics of Learning. Retrieved from:
http://d3dkdvqff0zqx.cloudfront.net/groups/apaadvocacy/attachments/apa\_dynamics-of-learning\_200707\_v2.pdf.

and emotional learning practices and positive discipline methods, improves students' educational outcomes and reduces the risk of suspension and expulsion.<sup>35</sup>

Moving forward, there will be a greater need for educators and other school staff to understand how to work with students who have experienced a traumatic event. Without training, educators may inadvertently exacerbate students' trauma, rather than provide appropriate support. To help accomplish this, APA recommends enacting the Comprehensive Mental Health in Schools Pilot Program Act (H.R. 3549), which provides resources for low-income schools to develop a holistic approach to student well-being by building, implementing, and evaluating comprehensive school-based mental health programs. This bill includes training for educators and other school staff to integrate social and emotional learning and evidence-based, trauma-informed practices into all aspects of school environments.

Furthermore, as the third-largest stream of federal funding for school-based health care services, Medicaid is a critical mechanism for meeting many of these needs among our most vulnerable students. It broadens access to physical and mental health care available through school-based health centers. School districts can use Medicaid reimbursement to fund health professionals and specialized instructional support personnel (e.g., school psychologists),<sup>36</sup> purchase and update specialized equipment, and connect eligible students with providers outside of school settings.<sup>37</sup> It covers a broad range of medically necessary services for children, including

<sup>&</sup>lt;sup>35</sup> Reyes, C., & Gilliam, W. (2021). Addressing challenging behaviors in challenging environments: Findings from Ohio's early childhood mental health consultation system. Development and Psychopathology, 33(2), 634-646. doi:10.1017/S0954579420001790.

<sup>&</sup>lt;sup>36</sup> Pudelski, S. (2017). "Cutting Medicaid: A Prescription to Hurt the Neediest Kids." AASA, The School Superintendent's Association Retrieved from:

https://www.aasa.org/uploadedFiles/Policy\_and\_Advocacy/Resources/CuttingMedicaid2018Addendum.pdf.

37 Centers for Medicare and Medicaid Services. (2003). "Medicaid school-based administrative claiming guide." Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsves.pdf.

certain screening, diagnosis, and treatment services. <sup>38</sup> Medicaid can also be used to pay for services described in a Medicaid-enrolled student's individual education plan (IEP) under the Individuals with Disabilities in Education Act.

To meet the growing need for physical and behavioral health services, including in schools, APA supports increasing the Medicaid Federal Medical Assistance Percentages (FMAP), as well as updating CMS' guides on Medicaid in schools to ensure that Medicaid reimbursement can be utilized for school-based physical and behavioral health care. In addition, we oppose restriction of Medicaid payments to schools for necessary services and the implementation of per-capita caps or block grant funding for Medicaid. Finally, we support the Committee's efforts to permanently extend the Children's Health Insurance Program (CHIP).

As we work together on these critical issues, we must also not force schools, families, and communities into a false choice between their children's education and mental well-being and their physical health and safety. Ideally, all students should be in physical classrooms with their teachers and peers. We can and should be doing everything possible to reopen schools safely, adhering to proven public health measures, while also providing students and families with virtual learning options in the event they become necessary. Federal, state, and local governments should be working in concert to ensure that all children receive continued access to equitable education and needed support services, while also staying mentally and physically healthy.

In summary, APA asks Congress to acknowledge the long-term impact of the COVID-19 pandemic on children's behavioral health and acknowledge how the nation's current approach to and infrastructure for behavioral health is failing to meet the critical needs of our children – this was true before the pandemic while the need has only increased. APA and its membership stand

<sup>38</sup> MACPAC: Medicaid and CHIP Payment and Access Commission. (April 2018). Medicaid in Schools Issue Brief. Retrieved from: <a href="https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf">https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf</a>.

ready to assist the Subcommittee with improving the health, safety and prosperity of children and adolescents in our nation.

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Ms. DeGette. Thank you so much, Dr. Evans. I'm now very pleased to recognize Ms. Danielpour for 5 minutes.

# STATEMENT OF KELLY DANIELPOUR

Ms. Danielpour. Good morning, Chair DeGette, Ranking Member Griffith, and members of the subcommittee. Thank you for the opportunity to speak—to share my perspective on the COVID-19 pandemic's impact on young people, and for recognizing the importance of this topic.

My name is Kelly Danielpour, and I'm the founder of VaxTeen, as well as a first-year undergraduate student at Stanford Univer-

sity.

In April 2019, at the age of 16, I came across a post on Reddit that stunned me. The author was the same age as me but was facing a situation I'd never had to consider. His parents refused to allow him to be vaccinated. He tried to reason with them but to no avail.

And he was concerned. Yes, he feared the danger that vaccinepreventable diseases posed to his own health, but primarily he was worried about the danger that he posed to those around him by being unvaccinated.

I was struck by his dilemma and by his profound consideration for others. It sent me down a rabbit hole of research, where I discovered that many of my peers had similar queries about vaccination yet there was a lack of clear answers

tion, yet there was a lack of clear answers.

I was inspired to create VaxTeen, an organization that communicates directly with teenagers and young adults to counter the growing antivaccine movement. We work to educate young [inaudible] their own health.

VaxTeen encourages those who are unvaccinated to catch up on vaccinations as soon as they are able to, to help them understand what vaccines they need, and how they can receive them, depending on the applicable laws in the State in which they live.

VaxTeen is also a platform to lobby for change. With teenagers nationwide now involved, we work both within our own communities and nationally to disseminate accurate information and encourage legislatures to enact policies expanding adolescents' access to vaccinations.

Clearly, much has changed since I discovered that initial Reddit post. About 1 year later, the World Health Organization declared COVID-19 to be a pandemic, and the fears I first encountered on Reddit became the fears of my entire generation.

When would we be able to get vaccinated? What role could we play in making that happen? What risks were we posing to those around us and that we cared about? Were we safe?

The time I've spent running VaxTeen has been filled with endless questions and searching for answers. Every day I speak to young people about what vaccines mean to them, the reasoning for why or why not they do or don't want to be vaccinated, and how they can protect themselves and their communities and those they care about.

There are certainly obstacles we're facing in convincing some young people [inaudible] vaccines have come to feel to most of us. They're a way back to normal, allowing us to return to school and see our friends. They're a way of protecting our families and communities.

Two years ago, the Senate Committee on Health, Education, Labor, and Pensions held a hearing entitled "Vaccines Save Lives: What Is Driving Preventable Disease Outbreaks?" Notably, among those testifying was Ethan Lindenberger, an 18-year-old whose mother's opposition to vaccinations led him to post on Reddit in search of information, catch up on missing immunizations without the aid of his parents, and become a vocal vaccine advocate.

The hearing concluded by fleshing out the irony that plagues vaccines: Their success in preventing outbreaks of disease has led

many to forget their effectiveness and impact.

The pandemic has served as a startling public health lesson. Even teenagers who haven't experienced the loss of a family member or friend due to COVID-19 have suffered from prolonged social isolation and witnessed the economic devastation brought on by the disease.

At this point, it's clear that we each have a responsibility to stop the transmission of disease through vaccination, social distancing, and other public health measures to ensure our collective health. I've witnessed many members of my generation take this to heart, volunteering for clinical trials [inaudible].

As we work to bring an end to the pandemic, I hope we'll continue to focus on the needs of young people, ensuring the safety in the classroom so that in-person learning can continue, helping them catch up on routine immunizations that were missed due to the pandemic, and expanding their access to vaccinations.

Thank you.

[The prepared statement of Ms. Danielpour follows:]

# United States House Committee on Energy and Commerce Subcommittee on Oversight and Investigations "Putting Kids First: Addressing COVID-19's Impacts on Children." September 22, 2021

**Testimony of** 

Kelly Danielpour Founder, VaxTeen

Good morning Chair DeGette, Ranking Member Griffith, and members of the Subcommittee. Thank you for the opportunity to share my perspective on the COVID-19 pandemic's impact on young people and for recognizing the importance of this topic.

My name is Kelly Danielpour, and I am the founder of VaxTeen, as well as a first-year undergraduate at Stanford University. In April of 2019, at the age of sixteen, I came across a post on Reddit that stunned me. The author was the same age as me but was facing a situation I'd never had to consider: his parents refused to allow him to be vaccinated. He had tried to reason with them but to no avail, and he was concerned. Yes, he feared the danger that vaccine-preventable diseases posed to his own health, but primarily, he was worried about the danger that he posed to those around him by being unvaccinated. I was struck by his dilemma and by his profound consideration for others. This sent me down a rabbit hole of research, where I discovered that many of my peers had similar queries about vaccinations, yet there was a lack of clear answers.

I was inspired to create VaxTeen, an organization that communicates directly with teenagers and young adults to counter the growing anti-vaccine movement. We work to educate young people on the importance of vaccines and empower them to make well-informed decisions regarding their own health. VaxTeen encourages those who are unvaccinated to catch up on vaccinations as soon as they are able to by helping them determine what vaccines they need and how they can receive them, depending on the applicable laws in the state in which they live. VaxTeen is also a platform to lobby for change. With teenagers nationwide now involved, we work both within our own communities and nationally to disseminate accurate information and encourage legislatures to enact policies expanding adolescents' access to vaccinations.

Clearly, much has changed since I discovered that initial Reddit post. About one year later, the World Health Organization declared COVID-19 to be a pandemic, and the fears I first encountered on Reddit became the fears of my entire generation. When would we be able to get vaccinated? What role could we play in making that happen? What risks were we posing to those around us and that we cared about? Were we safe?

The time I've spent running VaxTeen has been filled with endless questions and searching for answers. Every day, I speak to young people about what vaccines mean to them, their reasoning for why they do or do not want to get vaccinated, and how they can protect themselves and those they care about. There are certainly obstacles we're facing in convincing some young people to get vaccinated — most often spurred by misinformation — but it is clear to me how vital vaccines have come to feel to most of us. They're our way back to normal, allowing us to return to school and see our friends. They're our way of protecting our families and communities.

Two years ago, the Senate Committee on Health, Education, Labor, and Pensions held a hearing entitled "Vaccines Save Lives: What Is Driving Preventable Disease Outbreaks?" Notably, among those testifying was Ethan Lindenberger, an 18-year-old whose mother's opposition to vaccinations led him to post on Reddit in search of information, catch up on missed immunizations without the aid of his parents, and become a very vocal vaccine advocate. The hearing concluded by pointing out the irony that plagues vaccines: their success in preventing outbreaks of disease has led many to forget about their effectiveness and impact.

The pandemic has served as a startling public health lesson. Even teenagers who haven't experienced the loss of a family member or friend due to COVID-19 have suffered from prolonged social isolation and witnessed the economic devastation brought on by the disease. At this point, it's clear that we each have a responsibility to stop the transmission of disease—through vaccination, social distancing, and other public health measures—to ensure our collective health. I've witnessed many members of my generation take this to heart: volunteering for clinical trials, helping others navigate the sign-up process for vaccination appointments, and trying to educate those around them. As we work to bring an end to the pandemic, I hope we'll continue to focus on the needs of young people--ensuring their safety in the classroom so that inperson learning can continue, helping them catch up on routine vaccinations that were missed due to the pandemic, and expanding their access to vaccinations. Thank you.

## Biography:

Kelly Danielpour is the founder of VaxTeen and a first-year undergraduate at Stanford University. At the age of sixteen, she was inspired to start VaxTeen after realizing that significant barriers prevented many of her peers from accessing vaccinations. The emergence of the Covid-19 pandemic a year later further highlighted the necessity of VaxTeen, which educates young people about the importance of vaccines and empowers them to make well-informed decisions about their health.

Ms. DEGETTE. Thank you so much, Ms. Danielpour, and thank you for taking time out of your academic day to be with us.

Dr. Hoeg, I'm now very pleased to recognize you for 5 minutes for an opening statement.

## STATEMENT OF TRACY BETH HOEG, M.D., PH.D.

Dr. Hoeg. Thank you. I'm so happy to be here.

My name is Tracy Hoeg, and I'm an American-trained physician and had the opportunity to go to Denmark to do an epidemiologyrelated Ph.D. and postdoctoral work. And I'm a mom of 10- and 13year-old boys, and I'm now living back in the United States and have had a bit of a unique perspective on the school reopening situation and COVID and kids because of my continued ties to Denmark and Europe and watching what my own children have been experiencing here in the United States.

And I was struck by the way Europe, and particularly Scandinavia, have been very good at prioritizing keeping children in school and reducing collateral damage of prolonged school closures, and they have, by default, kept their schools open as much as possible. And even Denmark has dropped all mitigation at this point

related to children.

And I became involved in multiple research studies, including published in MMWR, and in particular that study in a systematic review found that children are approximately 20 times more likely to be infected outside of school than inside of school.

And we need to keep that in mind. When we look at our mitigation strategies, you know, how much of an impact are they having at protecting our kids from the effects of COVID-19, and what are the disadvantages to those continued mitigation strategies, including quarantines and limited access to school and sports of different

So when we look at the situation in terms of risks and benefits, we need to consider both the risks to children from COVID-19 as well as the risks from the secondary effects of the mitigation. And we've learned more and more that children have a lower risk than we initially thought, with looking at zero prevalence data, have a risk of about 1 in 500 to 1 in a thousand chance of being hospitalized if infected. And that's about a 30 times decreased risk as an 80-or-older-year-old.

And then in terms of deaths, we've had about 5 to 6 per million in children. And for—comparing to 80-year-olds and older, that's about a 10,000-fold decreased risk.

And then we need to also, as others have acknowledged, note that this has actually not changed with Delta, the severity, though it's become more—though it is more contagious, most likely.

And we also need to remember that unvaccinated children have about the same risk of hospitalization as 40- to 50-year-olds who are fully vaccinated.

Recent data on long COVID from the U.K. has actually, when you look at controls compared to infection—infected children, has not found a difference in the rates of symptoms in terms of long COVID symptoms, and that's currently most likely the best study that we have.

So while long COVID most likely does exist in some children, it's not as big as a problem or not as large of a magnitude of a problem as we had originally feared. So that's reassuring, not to discount the children who have suffered from it.

And then we need to consider these risks in context of the other risks posed to children. And children have—ages 5 to 14 have a suicide risk that's greater than—dying of suicide is greater than 7 times the risk of dying from COVID. And we've seen consistent increases in mental health visits.

And we've also seen, of course, increases in obesity, doubling of the rate of obesity, and twice the rate of diabetes, per one study, in our children. And all of this while we know that schools can open safely, from my own research and from Europe even before we had adult vaccination. And we now also have access to rapid testing that we should be using at all schools to keep kids, as much as possible, in school, in sports, and their normal activities.

So at this point, I would say the burden of proof needs to be on our mitigation strategies to make sure that they're working and that they're not causing excess damage to the health of our children, and this would include quarantines and limited access to school and sports.

We need to make sure that these are having the intended effect and look to our own studies and our peer nations in Europe for guidance.

Thank you very much.

[The prepared statement of Dr. Hoeg follows:]

Testimony of Tracy Beth Høeg, MD, PhD
Before the Committee on Energy and Commerce Subcommittee on Oversight and
Investigations U.S. House of Representatives
"Putting Kids First: Addressing COVID-19's Impacts on Children"
September 22nd, 2021 Washington, DC

## The Risks to Children from COVID-19 and the Disproportionate Price they have Paid

I am a Danish American and have observed over the last year and a half strikingly different strategies between Denmark and the United States when it comes to prioritizing the overall wellbeing of children. Denmark reopened schools after six weeks of initial lockdown before the rest of the economy in April of 2020 and, almost without exception, kept them open and have only had two pediatric deaths in the entire country. Sports and extra-curricular activities have also been kept open and normalcy to the greatest extent possible in children's lives has been a national priority in Denmark since the start of the pandemic. In the United States, unfortunately prolonged school closures have led to learning loss, isolation, obesity and mental health problems in children disproportionately affecting socioeconomically disadvantaged children. None of this appears to have spared them from the negative impacts of COVID-19 either. In my view, the United States' single-minded, myopic approach to the pandemic has created a myriad of public health problems for children beyond that of COVID-19. I feel that our country's failure to do a risk-benefit analysis as well as good scientific studies of the interventions we imposed upon children to mitigate one disease has created numerous additional and avoidable public health crises in our youth. For a disease that relatively spares them, this generation has suffered an incredible amount during the pandemic and, unfortunately, the effects of this will likely travel with them for the rest of their lives.

#### The risks to children from SARS-CoV-2

If infected with COVID-19, children ages 0-9 have on average a chance of 0.1% or 1/1000 of being hospitalized and, for ages 11-19 a 0.2% or 1/500 chance of being admitted to the hospital (Herrera-Esposito, 2021). This is based on seroprevalence data from eight locations around the world: England; France; Ireland; Netherlands; Spain; Atlanta, USA; New York, USA; Geneva, Switzerland. The infection fatality rate for 0–9-year-olds is estimated to be <1/200,000 (<5/million) and 1/55,000 for 10–19-year-olds.

Age	ISR % (Crl)	ICR % (Crl)	IFR % (Crl)
0-9	0.094 (0.049-0.167)	0.0080 (0.0038-0.0147)	0.00048 (0.00021-0.00091)
0-19	0.20 (0.11-0.33)	0.021 (0.012-0.036)	0.0018 (0.0009-0.0031)
20-29	0.42 (0.26-0.67)	0.057 (0.035-0.088)	0.0067 (0.0038-0.0107)
30-39	0.90 (0.57-1.35)	0.15 (0.11-0.22)	0.025 (0.016-0.038)
40-49	1.9 (1.2-2.8)	0.41 (0.29-0.57)	0.097 (0.065-0.137)
50-59	4.0 (2.6-5.9)	1.1 (0.8-1.5)	0.37 (0.25-0.53)
60-69	8.2 (5.3-12.2)	3.0 (2.0-4.3)	1.4 (0.9-2.1)
70-79	16.1 (10.1-24.0)	7.7 (4.8-12.0)	5.2 (3.1-8.2)
80+	29.1 (18.2-42.0)	18.5 (10.8-29.3)	17.3 (9.7-27.5)

(Herrera-Esposito, 2021)

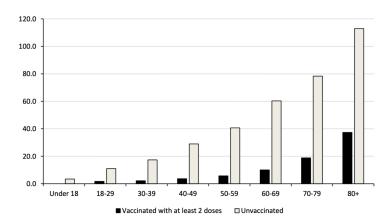
A separate analysis using data from the United States shows 5/million population deaths attributable to SARS-CoV-2 in the US since the start of the pandemic (Ioannidis, 2021).

The overall pediatric hospitalization risk from COVID-19 is currently estimated by the CDC to be 0.78% per case (CDC, Estimated COVID-19 Burden, 2021). But this was not based on seroprevalence data, so is an overestimate by 4-8 fold based on the above seroprevalence data. Consistent with this, a recent estimate found only 18.1% of children with SARS-CoV2 have symptoms (Poletti, 2021) and most of these would not have been identified as cases if seroprevalence studies were not done. This highlights why it would be useful for the US to use seroprevalence data in their estimates of risk in children. Research in the US has also found rates of pediatric hospitalization reported to the public may represent a 40% overestimate, based on COVID being an incidental diagnosis on hospitalization approximately 40% of the time (Webb, 2021; Kushner, 2021, Beck, 2021), which has given a consistent overestimate to Americans of what the pediatric hospitalization rates and number are for COVID-19.

Recent data from Public Health England (PHE, 2021) also found that unvaccinated children have a decreased risk of hospitalization unvaccinated when compared with fully vaccinated 40–49-

year-olds (3.4/100,000 vs 3.6/100,000 during this 2-week study period)

(d) COVID-19 cases whom presented to emergency care (within 28 days of a positive specimen) resulting in an overnight inpatient admission  $\frac{1}{2}$ 



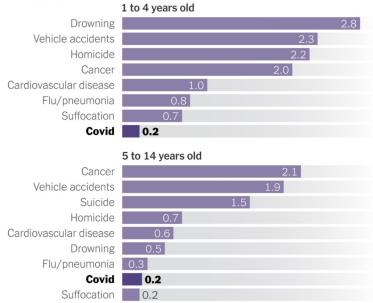
(PHE, 2021)

This is important perspective for developing public health policy if unvaccinated children should be viewed as similar in risk to unvaccinated adults in their forties.

In terms of mortality risk to children, COVID-19 should also be put in the context of other risks. COVID-19 has a lower annual mortality risk to children than motor vehicle accidents, influenza (by this estimate) and, perhaps most importantly for the 5-14 year olds, suicide (Leonhardt, 2021).

## Annual Deaths Among Children in the United States

Per 100,000



Covid data is for the 52 weeks ending April 10, 2021. Other data is for 2018.

By The New York Times | Source: Centers for Disease Control and Prevention

During 2019-2020, for example, 199 influenza deaths in children were reported to CDC but their own statistical modeling suggests approximately 434 deaths may have occurred (CDC, Flu & Young Children) compared with 439 deaths due to covid over 18 months of the pandemic (CDC, Weekly Updates, 2021).

Two studies recently reported on by the AAP found that, though delta has resulted in increased case numbers in children, the severity of the disease per case does not appear to have increased (AAP, 2021).

Long-COVID in children has also been a significant concern. Our understanding of Long-COVID in this age group has continued to evolve. It has become increasingly apparent that when studying this condition, it is essential to include a control group and a large enough number of subjects. In this recent report from the Office of National Statistics (ONS, 2021) in the UK, the prevalence of persistent symptoms 12-16 weeks after COVID were no different between those with a COVID infection and controls. One should, in particular, note that in the 2-11 year old age

group, there were fewer symptoms reported in the 2-11 year olds that had had COVID than those who hadn't (though this was not significant).

Table 1: Percentage of study participants (with 95% confidence intervals) reporting any of 12 symptoms four to eight weeks or 12 to 16 weeks after COVID-19 infection UK: 26 April 2020 to 1 August 2021

	Group	4 to 8 weeks aff	ter infection	12 to 16 weeks a	after infection
		Participants with COVID-19	Control participants	Participants with COVID-19	Control participants
	All people	9.4 (9.0-9.9)	4.1 (3.8-4.4)	5.0 (4.6-5.4)	3.4 (3.1-3.8)
	Males	8.1 (7.5-8.8)	3.7 (3.3-4.1)	4.5 (4.0-5.1)	3.3 (2.9-3.8)
	Females	10.7 (10.0-11.4)	4.4 (4.0-4.9)	5.4 (4.9-5.9)	3.6 (3.1-4.0)
Ì	Age 2 to 11 years	3.3 (2.5-4.5)	3.6 (2.7-4.8)	3.2 (2.3-4.5)	4.1 (3.0-5.5)
d	Age 12 to 16 years	4.6 (3.5-6.0)	2.9 (2.1-4.0)	3.0 (2.1-4.3)	1.3 (0.8-2.3)
	Age 17 to 24 years	5.6 (4.4-7.1)	3.6 (2.6-4.8)	3.6 (2.5-5.1)	3.6 (2.5-5.1)
	Age 25 to 34 years	7.6 (6.5-9.0)	5.8 (4.8-7.1)	4.5 (3.5-5.7)	3.5 (2.7-4.7)
	Age 35 to 49 years	11.3 (10.2-12.4)	5.0 (4.3-5.7)	5.5 (4.7-6.4)	4.5 (3.8-5.4)
	Age 50 to 69 years	12.5 (11.6-13.4)	3.8 (3.3-4.4)	5.8 (5.1-6.5)	3.1 (2.7-3.7)
	Age 70 years	9.3 (8.1-10.8)	2.8 (2.1-3.6)	5.3 (4.3-6.5)	3.1 (2.3-4.1)
	Without health conditions	8.6 (8.1-9.1)	3.9 (3.6-4.3)	4.5 (4.1-4.9)	3.1 (2.8-3.5)
	With health conditions	13.9 (12.6-15.4)	4.9 (4.1-5.8)	7.4 (6.3-8.6)	5.0 (4.1-6.0)
	Cycle threshold <23	12.0 (11.1-13.0)	N/A	5.5 (4.9-6.3)	N/A
	Cycle threshold 23 to <30	10.7 (9.8-11.8)	N/A	5.2 (4.5-6.0)	N/A
	Cycle threshold 30	6.8 (6.2-7.4)	N/A	4.4 (3.9-5.0)	N/A

Source: Office for National Statistics - Coronavirus Infection Survey

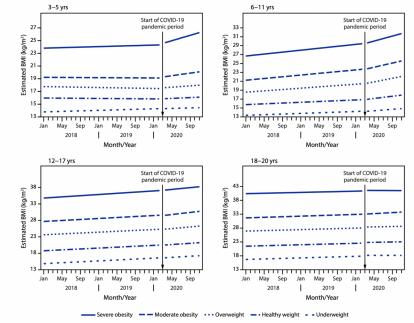
According to the CDC, there have been 4661 cases of multi-inflammatory syndrome in children (MISC) since the beginning of the pandemic out of 74 million children, with likely >40% of children in the United States being infected, based on CDC estimates from May (CDC, Health Department, 2021).

#### Other Public Health Problems are Growing in Magnitude among Children

Given the risks above and the access to all adults of highly-effective vaccinations against hospitalization for and death from COVID-19, we should agree to start focus on minimizing the collateral damage from prolonged school and sports closures and other restrictions on normal life for our youth. The below are downsides to restrictions that should be considered in risk benefit analyses.

Obesity

A recent study published by the CDC (Lange, 2021) found "Of 432,302 persons aged 2–19 years [...] the monthly rate of increase in BMI nearly doubled during the COVID-19 pandemic compared with a pre-pandemic period." This appeared to most severely impact the 3-11-year age group.



From Lange et al, 2021.

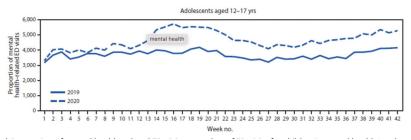
Accelerated weight gain, especially among children who are overweight or obese, can cause long-lasting metabolic changes that put children at risk for serious and costly co-occurring conditions, such as type 2 diabetes, hypertension, and depression (Bacha, 2016; Morrison, 2015).

## Diabetes

Preliminary results from a study from Louisiana also found over a doubling of new Type 2 diabetes diagnosis in children during the pandemic compared with the previous year (Basen, 2021)

Mental Health

Data published by the CDC (Leeb, 2020) found that, from April to October of 2020, Emergency Room visits for mental-health related visits for children aged 5-11 and 12-17 years increased approximately 24% and 31%, respectively.



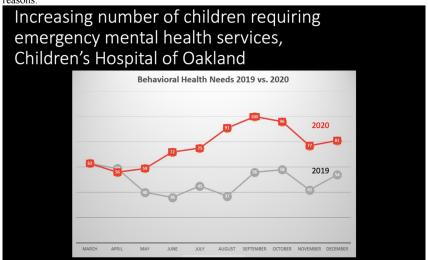
From Leeb et al 2020.

Another CDC-published study (Adjemian, 2021) found a relative 2.6x increase in Emergency Department visits for suicidal idea ideation/attempt/intentional self-harm among children <18 years.

TABLE 2. Prepandemic to pandemic\* changes in the number of weekly emergency department (ED) visits' among children aged <18 years and prevalence ratios (PRs), by diagnostic categories with the highest and lowest PRs\*\*-National Syndromic Surveillance Program (NSSP), United States, December 15, 2019–January 16, 2021

Diagnostic category	Absolute change in mean no. of weekly ED visits	PR (95% CI)
Highest PRs		
Exposure, encounters, screening, or contact with infectious disease	6,175	9.22 (9.01-9.43)
Calculus of urinary tract	18	2.70 (2.44–2.98)
Open wounds to limbs, subsequent encounter	9	2.67 (2.34–3.06)
Suicidal ideation/attempt/intentional self-harm	174	2.64 (2.57–2.72
Sexually transmitted infections (excluding HIV and hepatitis)	5	2.57 (2.26-2.94
Socioeconomic/Psychosocial factors	22	2.56 (2.41-2.72
Lifestyle/Life management factors	12	2.55 (2.36-2.76
Schizophrenia spectrum and other psychotic disorders	6	2.55 (2.27–2.86
Feeding and eating disorders	2	2.52 (2.18-2.92
Open wounds of head and neck, subsequent encounter	4	2.51 (2.26-2.79

Below are Data from Children's Hospital Oakland courtesy of Jeanne Noble, MD, which show a similar trend in increasing amounts of children needing emergency care for mental health reasons.

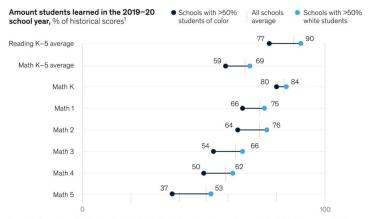


## Learning Loss

A McKinsey Report found minority children to be falling further behind, but all children experiencing learning loss during the pandemic compared with prior gains (Dorn, 2020). We need to keep this in mind in our quarantine policies and ensure that quarantining students actually has enough effect to rationalize further exacerbating learning loss, not to mention the mental and physical health issues discussed above. The below Figure shows how math scores

have decreased the most in schools with >50% students of color.

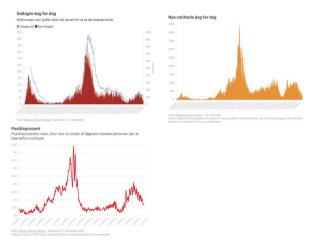
#### Most students are falling behind, but students of color are faring worse.



<sup>1</sup>Percent of an \*average\* year of learning gained by students in 2019–20 school year, where 100% is equivalent to historical matched scores over previous 3 years Source: Curriculum Associates

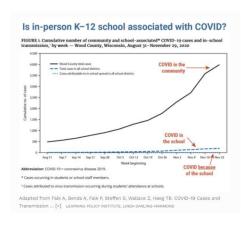
Exhibit from "COVID-19 and learning loss – disparities grow and students need help", December 2020, McKinsey & Company. Copyright (c) 2021 McKinsey & Company. All rights reserved. Reprinted by permission

We should all share the goal of minimizing overall harm to children. In this we should look at the overall risk to children in context as the UK, and Northern Europe have done in keeping schools open unless absolutely needing to close them, implementing test-to stay programs for children who are exposed at school and looking at metrics for removing masks, distancing and other school restrictions. In Denmark, for example, all school restrictions have now been lifted and they, like the rest of Scandinavia kept school open with very few exceptions. Denmark provided free child care during brief school closures for essential workers and paid sick leave. Vaccinations for all have been by choice but the adult vaccination rate, for example, in Denmark is very high vaccination rate at 74% and dropped all restrictions in schools and for the entire country on September 10<sup>th</sup> and has had falling cases and hospitalizations since that time (Politiken, 2021).



Hospitalizations, new cases and test positivity in Denmark as of 9/19/2021 (Politiken, 2021).

There have been a number of American studies documenting low rates of COVID-19 transmission in schools. These studies from North Carolina (Zimmerman, 2021), Wisconsin (Falk, 2021) and Utah (Hershow, 2021) all saw that less than 5% of COVID cases in schools came from *within* the school, while over 95% of the time kids were infected in the community or at home and then came to school already infected. I was senior author (listed last by tradition) of the Wisconsin study (Falk, 2021) published by the CDC and the amount of in-school transmission and cases identified at school are shown below. Only 7 of the 191 (3.7%) cases among the students were transmitted *in* the school.



Scandinavian schools saw a very similar pattern (Brandal, 2020) despite lack of distancing and masking for children <12; only around 1% of COVID cases in school spread further among the students there as well.

Recent September 2021 data out of Los Angeles have shown an even lower secondary attack rate of only around 1/500 or 0.2% of school contacts for this school year. "As of last week, among the almost 30,000 people that ended up quarantined, 63 tested positive." This was reported to KTLA by Los Angeles County Public Health Director Barbara Ferrer (Habeshian, 2021) Of note, there was no information included on severity of these cases among the children or vaccinated teachers. The downsides of continued quarantines include more learning losses, more time out of sports, recess and physical education, isolation and disruption of relationships.

Coming together to do the best thing for our nation's children should involve an honest and apolitical look at the science including both the risks to children from COVID-19 as well as the risks from our disease mitigation. The latter *also* pose serious short and numerous long-term health risks, which are unfortunately already apparent as described above. We should minimize overall harms where possible, keeping in mind restricting access to school and sports most greatly impact children with special needs and children from socioeconomically disadvantaged backgrounds. All adults have access to vaccines that are highly effective at preventing severe disease and rapid testing can be utilized to keep children in school and extra-curricular activities. Equal access to education, youth sports and human interaction have an enormous value which we should not lose sight of as we emerge from this pandemic and consider the overall well-being of our nation's children.

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Ms. DEGETTE. Thank you so much, Dr. Hoeg.

This concludes the opening statements, and now it's time for Members to be able to ask questions to the panel.

The Chair will recognize herself for 5 minutes.

And I will agree that the risk—with all of our experts—the risk to children from COVID-19, from serious long-term illness and death, is lower than it is for most of the population. But all the parents of young children that I know, including several of my staff, that does not give them a lot of comfort in their daily lives.

They want to make sure—and the other thing I'll say is most schools in this country are now open. And so the issue for us to all determine is what's the best way to keep our kids and their families and their communities safe as we reopen the schools, which we all agree needs to happen. And, of course, that answer is to make sure that every child who's eligible for a COVID—19 vaccine can get one.

As we've learned, though, and I know that all of our esteemed experts here and on Webex will say, children are not just simply little adults. And one of the reasons we had to have the studies and clinical trials for these vaccines is to make sure that the vaccine dosage is correct and to make sure that the vaccines are safe and effective.

Pfizer has said it will be submitting a request for Emergency Use Authorization for children ages 5 to 11 in early October. And then, as has been noted, the FDA may take several weeks to assess the data. The data will follow. And we saw some interesting news from Johnson & Johnson yesterday.

So, Dr. Beers, I want to ask you, FDA recently said they will work as expeditiously as possible to—to—while still following the science when it comes to authorizing a COVID vaccine for children. What safety factors will FDA be reviewing in this data that's different for children than compared to adults?

Dr. BEERS. Yes, absolutely, thank you for that. And I do agree that a safe and effective vaccine for 5-to-11-year-olds will be a wonderful thing to have.

And, you know, part of what the FDA is going to look at is, of course, the safety data, to make sure that there were no additional safety events or unexpected safety events. One of the things they'll look at is the effectiveness of the vaccine at the dosage that it was given.

I think what we've heard from Pfizer is that it's likely to be about a third of the dose—

Ms. DEGETTE. Right.

Dr. BEERS [continuing]. Of the adult dose. So they will be looking

at a number of those things.

Ms. DEGETTE. Now, when Pfizer submits the application and when with the FDA does their review, what should the parents know about the rigor of this process, and why do you think that they should have confidence in the FDA and CDC's recommendations?

Dr. BEERS. Well, thank you. I think, in short, it's an incredibly rigorous process. It's an incredibly cautious process. We do this all the time when we think about vaccine development in children. We always start with adults, and then we slowly work our way back-

wards to make sure that anything we're recommending for children is safe and effective.

Ms. DEGETTE. Thank you.

Dr. Evans, I want to ask you, obviously protecting our children from COVID-19 can't be parents' only focus as we learn about these exacerbated mental health struggles. So briefly, with the mental health and well-being in mind, what can parents and communities be doing right now to support youth and prevent crises?

Please turn your mic on. Thanks.

Dr. Evans. Yes, sure. Well, I think a number of things. I think the first thing that parents need to recognize is that one of the biggest predictors of how well the children will do is how they do. And around a lot of these issues, it's been a lot of anxiety, a lot of, you know, issues with people talking about these issues. And so the first thing they have to recognize is that they have to take care of themselves.

I think the other is that children are being affected by the pandemic, but not only the pandemic, all of the things that are around the pandemic, the financial uncertainty and other issues. And that they have to be on the lookout for those kinds of signs and symptoms that their children are experiencing difficulty and make sure that they're doing everything that they can to connect their children to services.

Ms. DEGETTE. Thank you.

Ms. Danielpour, I'm going to ask you, while your peers and younger teens are rightly focused on the school day right now, if they could hear just one message from you on the importance of

getting the vaccine, what would it be?

Ms. Danielpour. Thank you. I think I would say, getting vaccinated is really our best tool to getting back to normal, getting back to our lives, as well as protecting everyone around us. [Inaudible] time has really proved that young people care about their communities and protecting their own health and those around them. And the vaccine is a great tool for doing so.

Ms. DEGETTE. Thank you. Thank you so much to all of you.

The Chair will now recognize the ranking member, Mr. Griffith, for 5 minutes.

Mr. Griffith. Thank you very much, Madam Chair.

Dr. Hoeg, the public school system in Montgomery County, Maryland, requires all students who may have been exposed to a student who tests positive to COVID-19 to quarantine for 10 days. But according to parents, a student who shows symptoms similar to those of COVID-19 at their school or in a classroom isn't being tested before the school district decides to send everyone who may have been exposed to that student home to quarantine.

This policy resulted in nearly 2,000 students being quarantined in a week and entire grades of children being out of schools. The county recently reversed that policy once they rolled out a new rapid COVID-19 testing program.

Should a testing strategy or program including rapid tests be in

place at schools to prevent unnecessary quarantining?

Dr. Hoeg. Yes, thanks for that question. That's a problem right now across the country, that children are being sent home when they've been exposed and quarantining, resulting in unnecessary educational losses and exacerbating the problems that we've been discussing. [Inaudible.] There was a very well-done study out of the U.K. that looked at the test-to-stay program, where they tested children who were exposed 5 out of 7 days of a week, and if they tested negative, you know, each morning, they were allowed to stay in school. And they didn't find any significant difference in terms of disease spread if they were quarantined or if they did that rapid-testing protocol.

And a number of districts across the United States have adopted that, and I would highly recommend doing that in schools. I would highly recommend that the CDC recommend that program to avoid further learning losses and exacerbating the secondary effects from

the pandemic on children.

Mr. Griffith. And I think you touched on my next question as well, because I was going to go to a new study from The Lancet, a medical journal, that found case rates were not significantly higher in schools that allowed close contacts of infected students or staff members to remain in class with daily testing than those that required at-home quarantines.

Have you looked at that study, and is that the same thing you

were just trying to say?

Dr. Hoeg. That is absolutely the same study I was looking—I was discussing, yes.

Mr. GRIFFITH. All right. That's what I thought. Sounded like it.

There went my second question, but I appreciate that.

You know, what are the impacts of social isolation on our children from school closures? What are you seeing? We've heard about

suicide, but what other impacts are you seeing?

Dr. HOEG. Beyond suicide, you know, it's screen time, it's increasing amounts of abuse at home, it's poor diet. You know, kids, when they're at home, you know, their parents are usually working, not inside of the house, and so it's been a concerning effect that kids are left to their own devises and not in PE or getting the same amount of physical activity, not going out to recess. And, absolutely, humans are social creatures—

Mr. Griffith. Yes, ma'am. Let me focus you in—let me focus you

in on one of those.

Dr. Hoeg. Yes, absolutely.

Mr. Griffith. Do we have any good data yet on the rates of abuse and neglect that we've seen during the pandemic? Is it up? Do we have any hard data on that? I mean, the supposition is it's up.

Dr. Hoeg. Yes, so the most—the most recent study I saw, it actually looked at infants and found that the rates of going to the emergency room with abuse was increased. But I actually haven't seen a study yet in older children, and I don't know if anyone else could speak to that, but that's clearly a concern.

Mr. Griffith. I see Dr. Beers nodding. That's one of the nice

things about being in the room together.

Dr. Beers, do you have some specific data on abuse and neglect

of children in school age as a result of the pandemic?

Dr. BEERS. Yes. No, I would agree with Dr. Hoeg that we're seeing some early data and certainly anecdotally we are hearing, but it is a concern. We agree.

Mr. Griffith. Yes. What—and I go back to Dr. Hoeg. I'm just curious. What about remediation for students in the school? I mean, what we're seeing, at least in Virginia—I think it's probably true across the Nation-is that things didn't get taught that were supposed to be taught because they didn't have time. I mean, my kids were at varying degrees, going 2 days a week, then doing 4 days a week as we got later into the year, but still doing a lot of virtual work as well.

What are we looking about in regard to remediation? I know we've gotten a tutor for our kids to try to help get them caught back up on what they were supposed to have learned during that

full year of COVID shutdown or virtual learning.

Dr. Hoeg. I'm glad that you brought up the fact that you got a tutor, because this just points out the fact that, because we have no national strategy for accelerated, you know, learning this year, that it's the kids who are socioeconomically disadvantaged and don't have access to a tutor, and with more school closures, that are going to fall further behind.

So it's concerning that we don't have a consolidated national strategy for catching kids up, because, as we've seen from the data, again, it's the more socioeconomically disadvantaged that have fall-

en the farthest behind.

Mr. Griffith. Yes, ma'am. So we need some remediation.

I appreciate it, and I yield back.

Ms. Degette. I thank the gentleman.

The Chair now recognizes the full committee chairman, Mr. Pallone, for 5 minutes for questioning.

Mr. PALLONE. Thank you, Chairwoman DeGette. It's alarming that, 20 months into the pandemic, COVID-19 cases among children are at an all-time high as the Delta variant continues to surge in communities across the country.

In fact, Dr. Rush, in your testimony you note that the number of hospitalized children due to COVID-19 has tripled at children's hospitals. So let me ask you a question: Why are hospitals like yours seeing such a dramatic rise in the number of pediatric patients with COVID-19?

I think that the mic is not on. Dr. Rush. Thank you so much.

I think it's multifactorial. Many of the public health measures that were in place in 2020 that separated children and that kept children more isolated, as we've all talked about this morning, also prevented the transmission of disease.

So children are now back together. They're in school settings, many of whom and at least in my community, have not had as rigorous restrictions around how to start—restart school. And so they are sharing germs again, and we've seen that all summer long with other viruses.

I think the Delta variant is much more contagious. A simple analogy is that, with the Alpha variant, the original parent strain, one person could infect two to three other people. The Delta variant, one person who is infected can infect seven.

So, if you think about the transmission of the disease, it's much broader. Children are unvaccinated, largely. In my area, in my region, even the teenage population is significantly below the national norms with vaccine availability. And so the disease—the Delta variant is just spreading more quickly.

Mr. PALLONE. Thank you.

Let me ask Dr. Beers. Last week, the—this committee advanced its portion of the Build Back Better Act, and that included a permanent extension of the CHIP program, more than a billion for activities to strengthen vaccine confidence, and 40 million to support children's mental and behavioral health needs.

So I just wanted to ask you, Dr. Beers: Thinking about the current state of children's and adolescents' health needs, how will those provisions or provisions like that support their well-being?

Dr. BEERS. Well, thank you very much for that.

And the AAP is very much in support of those provisions. I think it's just incredibly important for us to be investing in the things our children need as we go forward.

A permanent CHIP extension would be music to every pediatrician's ears and something that would allow more children to get ac-

cess to the healthcare that they need.

In addition, the additional mental health support, as you heard from Dr. Evans and all of us, I think, are sorely needed, and we need to make sure that we're putting those resources where children are and where they're living, schooling, and playing. So it would be incredibly valuable.

Thank you.

Mr. PALLONE. Well, thank you.

But I also wanted to mention that the Build Back Better Act included 250 million for our Children's Hospital GME, graduate medical education. So let me go back to you, Dr. Rush. Do you and the Children's Hospital Association support that level of increase for Children's Hospital GME, and do you believe it would help address workforce shortages in pediatric and subspecialty care areas?

Dr. Rush. One hundred percent. Most children's hospitals are affiliated with academic medical centers and actually are the core of pediatric graduate medical education as well as research. And so this funding would ensure that all of those training programs, not only for the general pediatrician in the community, but also for all the pediatric subspecialists, who largely work in children's hospitals, going forward.

Mr. PALLONE. Well, thank you.

Let me just—one final question for Ms. Danielpour. And I know you don't speak on behalf of all young people, but I think we can benefit from your insight.

What single action do you believe young people want to see from adults that would help instill confidence that we still care about

them?

You know, people always say, well, Congress doesn't really care about young people as much as seniors because they don't vote, right? But, I mean, is there something that we could do that would—or that you believe adults could do to help instill the confidence that we do care? I know it seems strange, but, you know, I hear that.

Ms. Danielpour. That's an incredible question to ask.

While I obviously don't speak for an entire generation, I think making young people part of the conversation, whether that is

somebody who is hesitant and has questions and what—who needs to be educated and learn why they should be vaccinated, as well as I think peer-to-peer messaging could be incredibly impactful, and in families.

I think adolescence is very much a lesson in learning how to navigate your family and cultural and socioeconomic issues that we have and what they mean to them. And so I think young people are uniquely poised to speak to those around them and to educate

And so I think one of the greatest things that our representatives can do is really involve young people in this conversation, make them feel heard.

Thank you.

Mr. PALLONE. Thank you. Thank you. Madam Chair.

Ms. DeGette. I thank the gentleman.

The Chair now recognizes the full committee ranking member, Mrs. Rodgers, for 5 minutes for questioning.

Mrs. RODGERS. Thank you, Madam Chair.

I too want to thank Kelly for joining us and for her advocacy. You know, it really is just breathtaking as I think about the impact on our children. And, in my circle of friends, I have one friend who-he told me over the summer that they can't get their daughter out of her bedroom. Another friend has had her 14-year-old daughter in the emergency room multiple times over the last year for cutting herself, and she's told her mom that all she thinks about is killing herself.

I have another friend who just last week shared with me a list her son has texted her. She forwarded this text to me from her son who had listed—I don't know—10 or 11—I was looking for it—of his friends who have committed suicide by name and their age. It's

just breathtaking.

Without a doubt, this pandemic has taken a toll—taken a deep toll on all of us and on our children in particular. And, as a parent and for many parents, they are understandably scared for their children's health and their well-being. The 24-hour news environment right now, you cannot escape the fear and the hysteria. The risk of COVID-19 must be taken seriously, but I believe we must have an honest conversation about all of the risks that are facing our kids right now—the crisis that our kids are in the middle of.

So, Dr. Hoeg, I wanted to ask: What is the risk of COVID-19what risk COVID-19 poses to children, and how does that risk

compare across age groups and compare to adults?
Dr. Hoeg. Yes. Thanks for bringing up those very important

points about mental health.

And so the risk for children, as I was discussing, for hospitalization is, you know, at 20 to 30 times lower than older adults. And we're talking, you know, a thousandfold difference in terms of risks of mortality. And then—and so the risks that—as I discussed earlier, you know, are about—are 1 in 500 to 1 in a thousand for hospitalization, and we've seen 5 to 6 deaths per million among chil-

And then could you repeat the second part of your question for me, please?

Mrs. Rodgers. I'm actually going to move on, because my concern is that we're taking this very narrow focus. We're focusing on COVID-19 while ignoring other health factors.

Dr. Hoeg. Yes.

Mrs. Rodgers. Other mental health, social, emotional development impacts of the policies that right now CDC and other public health agencies across the country are enforcing.

So, Dr. Hoeg, would you just speak to, you know, when we're implementing these mitigation policies for COVID-19, why it's important for us to also consider the other health factors and that impact on our children—mental health, social, and emotional development.

Dr. Hoeg. Yes. Absolutely. I mean, looking at—we need to look at a holistic view of children's health and not just look at one disease, because, as I was discussing, you know, suicide poses a 7 times increased risk of death than COVID does in children in the 5 to 14 age group.

And, you know, it's kind of ironic that, you know, while we're trying to keep these kids 100 percent safe, you know, that they're feeling abandoned and they're seeing these increased problems of men-

tal health and suicide.

And so, you know, I think that's also something that has-where the United States has differed from Scandinavia and from Europe, because they've been acknowledging, you know, that other threats to children's health are, in many cases, you know, more important

and of greater magnitude than COVID is.

And so we need to make sure that, while we're protecting kids from COVID, that we're not increasing the risk of these mental health problems of-and obviously obesity and diabetes, they're not things that are necessarily going to, you know, kill children or immediately, but they're lifetime health problems that we need to be concerned about.

Same with mental health, so-

Mrs. Rodgers. Thank you.

The CDC currently recommends all children ages 2 and up wear a mask indoors. That is not what our international partners have advised.

For example, the European CDC recommends masking adults but not kids in primary school. UNICEF and the WHO recommend against masking kids under the age of 5.

Dr. Hoeg, why do you—why do you think the U.S. is recommending masking kids as young as 2 years old?

Dr. HOEG. I mean, that's a good question. I think that's because there is a lot of belief that masking young children is having a large impact on the transmission of the disease in the United States. And I think that Europe has been better at acknowledging that we actually don't really have solid data showing that masking children has had an impact—masking children in schools particularly has had any impact on preventing—
Mrs. Rodgers. Yes. Thank you.
Dr. Hoeg [continuing]. Widespread disease.

Mrs. Rodgers. Thank you. My time has expired.

I might just mention, when the Director Walensky called to tell me about this mask recommendation, I asked her for the science, and she said, "I'll get it to you."

I vield back.

Ms. DEGETTE. I thank the gentle lady.

The Chair now recognizes Ms. Kuster for 5 minutes. Ms. Kuster. Thank you very much, Madam Chair.

And I want to thank the ranking member of this subcommittee, Representative Griffith, for emphasizing vaccines. Children would not need to wear masks if more adults would vaccinate, and I wish that the ranking member of the full committee would focus on that

Nobody's suggesting that we are not focused on the mental health of children and adolescents. Children and adolescents in our country were already facing a growing mental health crisis before COVID-19, and today they are struggling with adverse childhood events, including trauma, racism, bullying, substance abuse disorder, and undiagnosed mental health issues.

So it is true that the pandemic has added to the stress, and I would like to join my colleagues on the other side of the aisle to put this pandemic behind us by focusing on increasing our vaccination rates. My schools in New Hampshire—one school announced today an outbreak of COVID-19. We have very high rates even though people have done everything they can.

So I think your effort to diminish the risk rings hollow. I'm a parent. I also have 12 great nieces and great nephews. I want to

do everything I can to keep them safe.

So we have found that, between April and October of 2020, there is a 24 percent increase in the proportion of mental health emergency department visits for children aged 5 to 11 compared to the

same period in 2019. Let's put this pandemic behind us.

And, right here in New Hampshire, I've seen firsthand the dire need in our rural communities for adolescent mental health. I had the opportunity in August to visit Mountain Valley Treatment Center in Plainfield, New Hampshire, where children come from throughout our State and throughout the country to cope with anxiety disorders and get additional treatment.

And COVID-19 has just increased the challenges for the young people that I met and their families. Nerves are frayed for parents and children alike. And so let's work together in a bipartisan way to keep everyone mentally healthy as we stay safe from COVID.

Ms. Danielpour, you have a unique perspective on this panel, and I'm wondering if you could give your perspective on how the pandemic has impacted you and your peers and what you recommend that adults in this country, and particularly right here in Congress, do about it?

Ms. Danielpour. Thank you.

I think that clearly the pandemic has had a tremendous impact on, I mean, everyone, really especially, though, young people. I

think it has been incredibly difficult.

But I also think it's been a time of extreme resilience that I've seen among my peers. I've had friends who spent their days during the-when at home, they would spend their free time delivering groceries to the immunocompromised or elderly who couldn't go to a supermarket, who created enrichment programs to help underserved schools in our area. They—children who—learning at home, who perhaps had a parent who couldn't speak English, or help with homework, wouldn't fall behind. I think, just as—no—I'm sorry—Representative Griffith mentioned that he did for his kids, and he

provided for them.

Everyone had increased responsibilities in their own families. I think we all witnessed—let's see—young people themselves went through so much. I mean, we're meant to be around other people. We learn so much from being in a classroom, from learning the experiences of others, from socializing.

We witnessed devastation in our own communities and our—perhaps our own families, perhaps the loss of loved ones. And so I think this has been a tremendously difficult time, I think for every-

one, but really young people in particular.

And I ask, I think, that we consider what it means to feel safe and healthy. I know Representative Rodgers spoke about education and mental health and this idea that young people should be in classes.

But I ask students that are at home—a girl named Megan, who contacted me, who—telling me that she had successfully convinced her parents to let her be vaccinated using vaccine resources. She was working in an ice cream store in Woodbridge, Virginia, who had—I believe it's Representative Griffith's area. And she was yelled at by customers who refused to wear masks, and she felt incredibly unsafe.

And I think, as we discuss getting back to normal and getting back to classrooms, I think there is so much to be said for the right to feel healthy and safe and protected that we cannot discount—and that the vaccines play a large role in mental health and that we shouldn't discuss them as something that opposes them or separate issues.

Ms. Kuster. Well, thank you so much. I appreciate your perspective. We could use that wisdom here in Congress.

And I yield back.

Ms. DEGETTE. Mr. Burgess, you're now recognized for 5 minutes for questioning.

Mr. Burgess. I thank the Chair.

And this is a terribly important hearing, and I'm always mindful of the fact that, as we've entered into this last 20 months where we've been dominated by a novel coronavirus, a duty to keep some humility about you, because you may be wrong in just a few months' time, and you may be demonstrably wrong and very publicly wrong. And, unfortunately, we've seen some of our leaders in public health fall into that.

And it's not a criticism of them. It's just a feature of the fact that you've got a novel illness that's very, very dangerous and where there is a lot of fear, a lot of fear on the part of parents and children both.

So I—I think this hearing is extremely important. I've already learned a great deal, and I think any—a great hearing is one that will perhaps lead to additional questions in an additional hearing. It's called congressional job security. But I think we clearly are not through with this.

And I just echo, too, with what Ranking Member McMorris Rodgers said. We need to hear from the heads of our agencies more than we are. It cannot take weeks and months to get a phone call answered on some of these very, very basic questions-questions around masks, questions around the development of vaccines for

These are important questions that our constituents are asking us. It's not us trying to be difficult to the agency head, but these are the questions that we are getting from our constituents when we go home, and we are, after all, representatives of the areas in

the country in which we represent.

But there's two issues that I'd really just like to focus on a little bit this morning. Dr. Evans, probably talking to you for just a second and then our two pediatricians. You know, I was struck the other day driving to my district office and Dr. Sanjay Gupta comes on CNN—and I hate to admit that I was listening to CNN. It was mostly just to get the talking points for the opposition.

But, still, Dr. Sanjay Gupta said—and I forget the figure that he gave, but it was a dramatic figure for the increase in suicide in young women and how different it was—I mean, it was—it was,

like, a lot.

And then, coupled with the articles that we're reading now in The Wall Street Journal, has published several articles on social media, and particularly Facebook and Instagram. And, in fact, Madam Chair, I took the liberty of printing off one of the Wall Street Journal articles, and I'd like unanimous consent to add that to the record. But it just strikes me that that is-

Ms. DEGETTE. If the gentleman will submit it, I'll review it.

Mr. Burgess. Yes. I'll be happy to.

That is an area where we, as a committee who has—yes, we have jurisdiction over public health. We also have jurisdiction over tech and tech issues. So it seems-and even Mrs. McMorris Rodgers brought it up here in our hearing last March about the development of products aimed for a population—this was the population we want to—we want to subscribe to our product, but it's also products of the age that may be actually being hurt by their product.

So would you care-could you comment on that? Is that something that you've encountered as well of the suicide risk for teens?

Dr. EVANS. Talking to me? OK.

Mr. Burgess. Yes, Dr. Evans-

Dr. Evans. Sure.

Mr. Burgess [continuing]. For teen girls and the effect of some of these—some of the social media platforms might be having on them.

Dr. EVANS. Sure. So I think it's important to look at these platforms both from the positives and the negatives, OK? When-many of you have talked about the impact of social isolation on children. We know that that has a very negative impact. And, actually, social media has been something that children—youth have within able to use to overcome that and make the connection. So, in that sense, it's positive.

But, as you point out, there are some negatives. The research around this is that it's how children use social media that is the biggest challenge. The social comparisons, the cyber bullying, those kinds of negative kinds of activities are the ones that really drive the negative impact that children have.

So I think our social policy, then, has to look at not only the length of time—and, actually, the data around that are not very—are equivocal, that it's not—there is not a strong correlation between the amount of time and the negative impact. It's more about how social media is used.

So I think our social policy, then, has to look at that.

Mr. Burgess. No. And it just underscores why-how it's-why

it's important for our committee to perhaps investigate that.

And, to our two pediatricians, reading about the vaccines in young men and the risk of myocarditis, and, when I first talked to the CDC, I thought, oh, you're just dismissing the females that complain about chest pain and fatigue, but apparently not. Apparently it's a real thing in young men, and the myocarditis appears to be self-limited.

But I don't think, again, we can just ignore it. We have to—we have to see it upfront and be honest about it. So would either of you care to weigh in on that?

Dr. BEERS. Yes, absolutely. I'm happy to, and then if Dr. Rush

wants to chime in, yes.

Yes, absolutely, and I think it's actually one of the strengths of our vaccine monitoring system, that we have actually been able to identify such a rare potential effect of the vaccine. And I think continued transparency about that. I—we remain confident that the risks of the COVID illness far outweigh the risks of the vaccine, and you can get myocarditis.

I will note I have a 13-year-old son, and he is fully vaccinated. So I feel personally confident enough in the data that my own son

is vaccinated.

Mr. Burgess. And don't misunderstand me.

Ms. Degette. Dr. Rush, do you want to add anything to that?

Mr. Burgess. I have been fully vaccinated myself, and I-

Dr. Beers. I know.

Mr. Burgess [continuing]. Think that is—

Dr. Beers. I know.

Mr. Burgess. It's important for that message to go out as well. Ms. Degette. The gentleman's time has expired, but I will allow Dr. Rush to answer the question.

Dr. Rush. Thank you, Chairwoman DeGette.

I would agree with Dr. Beers. I think that the rigor with which vaccine and all immunizations are studied in children is rigorous and ongoing. I think we are learning about the risks of myocarditis

and pericarditis following vaccination.

I think, if you adjudicate some of the data that exists in the passive surveillance databases, such as VAERS, you will actually see that—that some of those cases are not as prevalent and that, actually, in preliminary studies that I heard about actually yesterday in grand rounds before I got on my plane, it shows that the risk of myocarditis right now is actually lower than the natural risk in the same age group.

So I think it will be followed. I think it will absolutely be studied

So I think it will be followed. I think it will absolutely be studied by pediatric scientists, and I think there will be intense multidisciplinary groups that come together to follow this long-term and will advise us—to your point, we will learn as we go and make adjust-

ments along the way.

Mr. Burgess. Sure. Well, as somebody-

Ms. DEGETTE. Thank you so much, Dr. Rush.

Mr. BURGESS. Thank you.

Ms. Degette. The Chair now recognizes Miss Rice for 5 minutes.

Miss RICE. Thank you, Madam Chair.

And I want to thank all the witnesses for coming today, and I'd like to start with you, Ms. Danielpour. You are such an impressive young woman. You've achieved so much in just your short time on this planet, and you really represent your generation so well.

You mentioned in your opening statement that you—after having a conversation with a friend of yours, you kind of went down the rabbit hole of trying to find information about certain things hav-

ing to do with this—with COVID and vaccines, et cetera.

And, because you are in the generation who has not—doesn't know life without cell phones and computers and tablets, unlike me, who grew up with none of that, I just—I'm curious about where you got your information, because, you know, we've had hearings, especially with this subcommittee, on the incredible increase in mis- and disinformation that is available on every single social media platform that I'm sure you spend and your generation spend time on.

So how is it that you were able to kind of parse through the information that you were finding on social media, to the extent that you were there, and find accurate information that informed you

and this kind of—your VaxTeen's effort that you started?

Ms. Danielpour. Thank you so much.

Yes. So I initially came across a post on social media that inspired VaxTeen, and it very much—the idea of the post is that this young person couldn't find information to help them, that they were asking this question, hoping for answers.

I think—I'm not sure how much time everyone here has spent perhaps on the CDC site, but I do think there is obviously a wealth of trustworthy sources out there, but they can be very incredibly hard to navigate, especially if you're someone who has-doesn't have a medical degree or know legal terminology.

And VaxTeen started—I spent an entire year reading resources comprised of CDC information and other trustworthy sources and distilling them and putting them for young people, understanding what they wanted to know and what language should be used that

they would understand, and putting them in one place.

And so I think there is something unique about the fact that my generation has grown up with obviously a wealth of information at our fingertips. And with social media I think we've uniquely developed tools in that sense to question information we see online, to hold it to a higher standard.

I know many young people who started political fact-checking organizations and do work to hold representatives accountable to that sense. And I think there is very much that is—it very much has been ingrained in us. I—in school, I had classes about checking the accuracy of sources and what was-what could I verify, and what should I trust?

And so I think, in that sense—and people are uniquely poised to be messengers and people we can reach. I do believe there is very much a need for greater education, for greater messaging, but especially that recognizes personal stories. I think not just hearing that the organization Dr. Beers represents agrees that we should be vaccinated, but also the fact that Dr. Beers said she vaccinated her

own son. I think stories like that are incredibly impactful.

And I think we should recognize that everyone has their unique experiences as well and have a whole network of people they can reach. And so I think there is very much a need for accurate information that we can trust but that also reach people where they

So, if that's on social media, in classrooms, educational settings, in club fairs at schools, I do believe young people have the tools they need to be the greatest messengers we can possibly have, and I think it's something that's underutilized at this moment.

Miss Rice. Well, you're an incredible role model, so thank you so

much for being so engaged.

Dr. Evans, you were talking about the impact of social media on the mental well-being-mental and emotional well-being of our children. I can't think of anything more destructive to the development of our young people and their mental and emotional wellbeing, and all you need to know is that the people who started all these social media platforms, they don't allow their children to have these tablets and to spend time on all of these social media websites that can be so destructive.

So what is—what can we do as legislators to rein in the impact and a lot of this has to do with parenting and how much parents allow their children to spend on, you know, how much time they allow their children to spend on their devices. But what can we do to try to rein in this toxic environment that we're allowing our children to grow up on?

Dr. EVANS. Well, I think one of the things is that we have to have better research. We heard about the research that Facebook did, didn't share it publicly. Now it's been exposed, but I think we have to, first of all, use science-based strategies to understand the

What we do know is, as I mentioned, that how children use social media does have an impact on their overall mental health and well-

being.

From a policy standpoint, I think we have to use that information to set—to set limits. I think parents have to set limits, particularly for young children, that the APA has come out against Instagram's proposal to have a special platform for younger children because the data just don't support that.

And so I think we have to use all of that information to form public policy, and especially those areas where we know children

are using social media in a way that's negative.

Ms. DEGETTE. Thank you. I thank the gentleman. The Chair now recognizes Mr. McKinley for 5 minutes.

Mr. McKinley. Thank you, Madam Chairman, and thank you for

holding this. I think this is an important topic.

But, as much as I'd like to talk about children and COVID, I think we need to discuss the elephant in the room. Why are people hesitant to get vaccinated? In my opinion, I think they've—one, they've lost confidence in the Government and the CDC and the FDA. And that wasn't helped by now Vice President Kamala Harris when she stated that she wouldn't get a vaccination developed under President Trump.

And, secondly, the misinformation is rampant on social media,

undermining people's trust in medicine and the vaccine.

So, instead of rebuilding confidence and dispelling misinformation, the administration has taken—he's—they're acting like bullies by requiring all Federal employees and contractors that have over 100 employees to have all their workers vaccinated by November 22nd.

Businesses are concerned about this. There is no guidance on this mandate. If employers are expected to comply by November 22nd, employees will need to do some serious soul searching to determine how and if they're going to comply by November 1st to get that first shot.

So businesses in my district this past week or so, we've been overwhelmed with questions. One—and so I can direct it maybe to you, Madam Chair. Maybe we can get some answers. Will there be religious and medical exemptions, and when will they be clarified prior to November 1st?

Who will provide the immunity for employers who have to fire their employees who are unwilling to get a shot? Vaccinations were likely not part of their employment contract when they hired on,

so who is going to provide them immunity?

What about workers who—employees who work remotely? Will

they be required to get vaccinated?

What about workers covered under the Older Americans Act? Will employers be provided immunity if they have to fire these

aged employees?

Again, currently, there is only one—Pfizer is the only one that's been fully approved for use by the FDA, so are we going to rely on a single source across America for this vaccination? And, if an employer is required to take the vaccine and then—the employee—and if the employee becomes sick from a side effect, will the employer be held legally responsible, or will there be immunity for him for having been forced to do this?

How long will these mandates last? What's the goal? What are the metrics? Are we trying to get to 100 percent vaccination rate?

Because we all know that's not going to happen.

So what about—what about the impact on our nursing and staffing levels in our healthcare facilities? They're already at a stretch-

ing point when we have this requirement.

What about the effect on—impact on national security when our key scientists with top-secret clearance leave the workforce and with them is that knowledge, the impact that they have because they don't want to comply with that?

And what about the impact on our children when their parents—either mental health, stress, or otherwise—when their parents lose

their job as a result of this?

So I return to the fundamentals. So, instead of another Big Government mandate, why shouldn't this administration be addressing the core problem, reinstilling trust in the Government and countering this misinformation that's out there about the vaccine?

Do any of you have comments about any of those questions?

Seeing none, Madam Chairman, I yield back the balance of my time.

Ms. DEGETTE. I thank the gentleman.

The Chair now recognizes Ms. Schakowsky for 5 minutes.

Ms. Schakowsky. Thank you, Madam Chair.

I thank all the witnesses today. I particularly want to focus my questions with Dr. Beers. But I want to talk about mis- and disinformation. You know, it was last—way last March that this—a different subcommittee, the Health Subcommittee, had a hearing on disinformation, and it was in May that members of this committee, including the chairman and the chair of the subcommittee, sent a letter—I was on it, too—to Facebook talking about the misinformation that is there.

But you mentioned it in your testimony, Dr. Beers, that you—you gave testimony that highlighted the dangers of the—and the role of COVID misinformation in vaccine hesitation and that you and other providers have to spend your time correcting false claims about the vaccines, and I just would like your—you to answer, you know, where are these myths being generated, and what do you think they have—why do you think that they have gained such traction right now?

Dr. BEERS. Yes. I thank you so much for that.

And I think it's an incredibly important question. And one of the things I'll highlight is that misinformation and disinformation around vaccines is not new to the COVID-19 vaccine. It's actually something pediatricians have been dealing with for a very long time and has been a challenge. It certainly has significantly increased with the COVID-19 vaccine.

And I think that comes from a number of different places. I think there are people who intentionally spread this information for any variety of reasons. I think, you know, that's—that's the way our social media platforms work. You know, you see things that are rein-

forcing to what your—to where you want to go.

I think, you know, the other piece, honestly, is just that this has been a scary, uncertain time, and so people look to try to find information. It's a lot to wade through. It's part of why we really do encourage families to come back to their pediatrician to talk this through. But sometimes that misinformation has reached such a kind of heightened pitch that those conversations can be very difficult.

Ms. Schakowsky. I wonder if you have particularly seen lines of misinformation that have targeted communities of color?

Dr. BEERS. Yes. We definitely have. You know, and I think it's also important to note that there are other very real and valid reasons for vaccine hesitancy across many different communities, and I don't want to conflate those things, and certainly community of—communities of color have some very real reasons to ask questions and distrust the medical system at times, you know, but, yes, we've certainly seen targeted misinformation at any number of communities, and particularly communities of color as well.

Ms. Schakowsky. I also wanted to talk—since we're talking about kids, about pediatricians, it seems, have been particularly targeted. You mentioned—I'm quoting now—have been, quote,

"harassed, booed, spit upon, and/or threatened," that they've even had to have some security.

I wonder, you know, beyond the personal cost of such attacks, how has this affected the ability to actually go after this misin-

formation?

Dr. BEERS. Yes. Yes. It's very difficult. And I do, you know—I—my role as president of the AAP is to guide the health and development of children, but also to the health and wellness of pediatricians and support pediatricians. And I worry very deeply about this, because it has—it has deeply impacted pediatricians. It is very difficult for them. It makes their jobs harder.

It is—many of them are losing staff because people are calling the office in—people are calling the office and not being very nice when they call the office, so many staff are leaving because of that,

and that's putting increasing strain on the health system.

So it's really—and I think what saddens me the most is that it takes away from the pediatrician's ability to do all those things that we do, you know, counsel new mothers and help a family with their child's asthma attack or, you know—you know, to talk them through a difficult period in their life, and it distracts from our ability to provide care to our patients and families.

Ms. Schakowsky. In the seconds I have, let me suggest that maybe this subcommittee could have an oversight hearing on that,

on disinformation.

And let me just say I have legislation, the Consumer Protection—Online Consumer Protection Act, which could hold these online purveyors of misinformation accountable for what they do.

And I yield back. Thank you so much. Ms. DEGETTE. I thank the gentle lady.

Mr. Palmer, you're recognized for 5 minutes.

Mr. Palmer. I thank the gentle lady for recognizing me.

I'd like to make a point, and I've heard several of my colleagues make this, and we've kind of danced around it, that, if you want to—Dr. Beers, you made the comment that you wanted to reestablish confidence in science.

I would suggest to you that, if you want to do that, you need to practice science and stop practicing political science. And I'm concerned that that's a lot of what's driving this debate. I was just looking at an article where the CDC was getting interference from the teachers' unions, and it had to do with a position from the CDC regarding the reopening of schools.

And, shortly after they put our their statement, they had an interaction from the American Teachers Federation, and they changed their position. The CDC tightened masking guidelines

after threats from the teachers union.

And I could go on. Here is a Washington Post article about the "CDC finds scant spread of coronavirus in schools with precautions in place," yet we persist in keeping the schools closed or—and, for instance, now it looks like we're headed toward mandating vaccines for our children as young as 5.

And that—that concerns me. It concerns a lot of people. I think what we're going to see out of this is what we've seen already during the pandemic, is a massive increase in the number of children being home schooled. And what we've seen through the years,

again, political science being applied to home schooled children to talk about socialization and issues like that, when in fact there's no issues with socialization in home schooled, but there is with kids in public schools who are being required to wear masks.

There is—we've had a massive increase in the number of eating disorders, like a 90 percent increase, a 50 percent increase in suicide attempts, emergency room visits because of suicide attempts

in different places.

And it's just disheartening, because you people are supposed to be the ones who have the greatest insight into children's health as pediatricians, yet we persist in getting conflicting information from the institutions that we should count on to be consistent.

That's what is really troubling about all this, in addition to the impact that it's having on children.

How would you respond to that?

Dr. BEERS. Well, thank you so much for the question.

I think, you know, certainly I can largely speak about my own organization, the American Academy of Pediatrics, and talk about how we have made our recommendations during COVID-19 pandemic.

We have issued approximately 30 interim guidance statements, which we—for each one, we convene a multidisciplinary workgroup of pediatric experts from across the country from a wide variety of fields who look at all the literature. They review that, they come together, they make recommendations, and then we review that literature for—

Mr. Palmer. I'm not interested in the process.

Dr. Beers. Uh-huh.

Mr. PALMER. I'm interested in the outcomes and what comes out in official statements.

And, for instance, talking about the socialization, and we know that it's not an issue with home schooled kids, but what's going on with the public school kids—and it's largely driven by the teachers unions—is in conflict with what I think the science shows.

And I think it's going to impact the politics, because the NEA membership is declining as more and more parents are getting fed

up with it. Teachers are getting fed up with it.

I would like to ask Dr. Hoeg a question, and that is: When you look at the antibody levels of young children compared to adults—I think the average age of a schoolteacher is 42. How would a—the antibody levels of a 5-to-11-year-old be relative to a 40-year-old?

Dr. Hoeg. So I just want to say, first of all, that this is not my area of expertise, but having looked at seroprevalence data, I have seen that the antibodies that we have been measuring have been persisting longer among children after they've been infected than among adults.

So I don't know if that completely answers your question, but they do tend to have a more robust antibody and T cell response

as well to the infection.

Mr. PALMER. Well, I raise that question because of the article

that I saw a few months ago—and I know my time, but—

Ms. DEGETTE. Not to be cutting the gentleman off, but we have votes coming up, and I want to try to get to all the questioning.

Mr. Palmer. What time are votes?

Ms. Degette. Any minute. Mr. Palmer. Oh. I yield.

Ms. DEGETTE. So we'd be happy to look at your article if you—

Mr. Palmer. I yield.

Ms. Degette [continuing]. Put it in the record.

I thank the gentleman.

The Chair now recognizes Mr. Tonko for 5 minutes.

Mr. Tonko. Well, thank you, Madam Chair, and thank you for

hosting this important hearing.

And I have questions that I want to offer the panel. But, before I do that, I would remind my colleagues and inform the panelists that I've authored a bill that addresses—would address through the Academy of Mental Health Institutes the mental health impact on frontliners and children of this COVID pandemic. And I think it certainly could incorporate the effects of social media on the mental health outcome.

So, with that, I'll continue. Among the best tools we have in our fight against the pandemic are safe and effective vaccines. Now that adolescents as young as 12 are eligible for these vaccines, hopefully with younger children eligible soon, they are playing an increasingly critical role in protecting millions of children in this country.

Understandably, parents are sensitive to safety considerations when deciding whether to vaccinate their children, even for children 12 and older who are eligible for the Pfizer vaccine.

So, Dr. Beers, how safe and effective is this vaccine for youth, particularly compared to other routine immunizations, such as those against the flu and measles?
Dr. BEERS. Yes. Thank you so much.

It's an extraordinarily safe and effective vaccine. We know, you know, millions of teens have gotten it so far. It's safe and effective, and in fact more effective than some of the other vaccines that we give. It has a very high efficacy.

And, again, I'll note both of my teenagers have gotten it. Mr. TONKO. Thank you. Thank you for your response.

And, Dr. Rush, in your testimony, you state—and I quote—"Tennessee is one of a number of Southern States where there is a degree of vaccine unreadiness and misinformation.'

Now, polling, such as that done by Kaiser Family Foundation, indicates that this hesitancy and misinformation may be shaping parents' decisions about getting their teens and 12-year-olds vaccinated against the virus.

Can you elaborate on that quote that you shared and the think-

ing behind it?

Dr. Rush. Well, I think that's what we have observed, certainly, as we have navigated the pandemic in the State of Tennessee and looked at the States around us, particularly as we monitored the beginnings of the Delta surge, beginning now almost 2 months ago, and as we have navigated the journey.

I think, as we have looked at our own experience at Children's Hospital, we are seeing some robust uptake amongst our greater than 12, and those are typically in families who themselves have embraced the vaccination. Many of our families are—remain hesitant, and our State, as well as some of our surrounding States, also lag behind some of the other States in the country with respect to the greater than 12 being vaccinated.

We anticipate that that will persist into the younger than 12—

Mr. Tonko. Uh-huh.

Dr. RUSH [continuing]. As well, and so, like we have shared, the pediatrician and the specialists who care for these children and families are the sources of truth. We do believe that these vaccines are safe, that the process to bring them to approval, even under Emergency Use Authorization, is a very rigorous process. Nobody wants to put a child at risk. So we believe in the safety of these vaccines for all children when they're ready.

Mr. TONKO. Thank you. And, Dr. Rush, again, what concerns have you heard from parents about vaccinating their kids, and how do you respond? How should parents be weighing the risks and the

benefits here?

Dr. Rush. I think Dr. Beers' comment was very relevant. These are safe. They've gone through the same rigorous process that all childhood immunizations have gone through, first testing in adults, first testing then in an age starting with the older children, and then moving to the younger children. That is the way all immunizations for children have been studied for decades.

There is rigor in looking at every side effect, tracking that side effect, doing the adjudication when surveillance data suggests that there may be an uptick in one or more side effects, really pulling together the experts that review that process under secondary and

tertiary processes.

I think the—we're scientists and pediatricians. We believe in the science, and we believe in the process. And I think those one-on-one conversations between pediatricians or other health specialists are invaluable to walking families, and even the teenagers as they make informed decisions, through that process.

And that's how I would respond.

Mr. Tonko. OK. I'll just conclude by indicating that, while we're talking about kids 12 and older who are eligible for the vaccine and as we continue now to look at younger than 12, ongoing trials are evaluating the dosing, the safety, and the efficacy of the vaccine in children under 12, and I would believe that FDA will review those data as they are submitted, possibly in the next couple of weeks. So there is hope there.

So, with that, Madam Chair, I will yield back.

Ms. DEGETTE. I thank the gentleman.

Mr. Dunn, you are recognized for 5 minutes. Mr. DUNN. Thank you very much, Madam Chair.

Children have proven to be more resilient to the physical effects of COVID-19 than adults, and hospitalization rates for infected children are, of course, much lower than for infected adults.

However, many children unknowingly have contracted the disease and passed on with little or no symptoms. So, despite the data supporting these findings, one of the most contentious debates a year and a half later is COVID policies in the school room.

Florida has a great story to tell here when it comes to keeping schools open. I believe our children's mental health has improved by our State's policies, and so has their parents' mental health.

And, given the low rates of hospitalization, low rates of serious disease among children, and that many cases go altogether undetected, I believe that we could be learning a lot about COVID-19 in children specifically by testing for natural immunity—that is, immunity secondary to infection.

And the most sensitive and specific tests are, of course, T cell—T, tango. So—and it's clear from the data that the immunity to SARS—CoV—2 is primarily mediated through T cell responses, not B. And testing schoolchildren for T cell immunity could truly guide science-based decisions about masking, social distancing, and vac-

cination policies.

I think another piece of the puzzle that's missing is, when it comes to kids and COVID, is cost-effective treatment options. You know, we appropriated billions of dollars to HHS to study and develop therapeutics. There were a number of them in the pipeline when we started this. And I'm, frankly, frustrated by the lack of treatment options that we have to show for that a year and a half later, although we did a great job with the vaccine.

I think all of us share the goal of wanting to protect our children from the pandemic. I fear, however, on the contrary, we are harming our children by disrupting their formative years and natural social development in an effort to control an uncontrollable virus by

secondary measures of isolation.

Dr. Hoeg, I'm concerned about vaccine mandates by governments on schools and private industry that ignore the considerations of natural immunity to COVID-19. How can we use that immunity testing to gather better information on how COVID-19 impacts kids and how to protect them?

Dr. Hoeg. Yes. I think that this is a great question, because it's something that a lot of parents, a lot of, you know, American citizens want to know, is how much protection does natural immunity

provide?

And, you know—and I think this is something that we haven't gotten as much information on as, for example, in Europe, and we're seeing, you know, some data in adults showing that natural immunity may actually provide better protection than vaccination.

But we really need to have a—some sort of a message and transparency from the CDC about exactly what the expected effects of natural immunity are, especially in kids when we're looking at, based on the CDC data put out in May, that there may be, you know, over 40 percent of kids in the United States have been infected.

And I know, particularly when it comes to the safety signal with the myocarditis among boys with the second dose, you know, a lot of parents would like to know what is the benefit of giving a second dose of the vaccine, especially in the kids who have already been infected?

And so I think these are sort of basic questions that a lot of people in the United States would like to know, and we haven't really had, you know, messaging about this from the CDC now many months later.

Mr. DUNN. Yes. I think that's low-hanging fruit to get that knowledge. I mean, it's a simple test that's available. We all know

how to interpret it. You know, we have experience with that, and it certainly bore out on the SARS-CoV-1 epidemic 20 years ago.

Dr. Hoeg, you published an op-ed in which you set the record straight on your research findings that were actually meant about the school policies as opposed to the CDC's policies, which, frankly, misrepresented your findings.

I commend your research. I commend you for setting the record

straight.

Is there a way we can measure the harm done to our kids when Federal agencies use the scientific community to push an agenda

regardless of the facts on the ground?

Dr. Hoeg. Yes. I mean, then we would have to know what the—you know, quantify the harms that were accrued from the prolonged school closures, you know, on children because of unwillingness to reopen the schools in a timely manner after we had the North Carolina study and our study from Wisconsin that showed that schools could be safely open.

And, in our study, we had varying degrees of distance between

the students----

Mr. Dunn. Let me ask you one more question before the-

Dr. Hoeg. Yes, yes.

Mr. DUNN [continuing]. Time expires. So is it fair to—again, to Dr. Hoeg: Is it fair to think that you would agree that social and mental health risks have been exacerbated by the CDC's failure to follow the science and by inconsistent messaging?

Dr. Hoeg. Yes. I do think that, yes.

Mr. DUNN. Thank you very much for your time. I thank the panel.

Madam Chair, I yield back.

Ms. DEGETTE. I thank the gentleman.

Chair now recognizes Mr. Peters for 5 minutes.

Mr. Peters. Thank you, Madam Chair.

I—this may be a hearing that we have gone over a little bit, but I am concerned that the pandemic has exacerbated disparities in physical and mental health of the—of our children as well as their

academic and developmental growth.

And I wanted to ask both Dr. Beers and Dr. Evans—and, Dr. Beers, you're not—you're a pediatrician. You're not an education expert, but you're a child mental health specialist. And, in this capacity and from your experience and leadership with the American Academy of Pediatrics, what do we know about how the pandemic has affected adolescent development and academic achievement and whether this will be long lasting? Dr. Beers?

Dr. BEERS. Yep. Yep. Now I've got it. I knew I was going to not

hit it once.

Thank you so much for that.

And, yes, I do—the effects on children over the past 18 months have been really substantive. It has impacted their public health, it's impacted their education, and those impacts have not been equitably distributed. I think children who are living in low-income families, often children in communities of color, who may have been children who have experienced greater amounts of grief and loss, are impacted more.

We're hearing this from our pediatricians across the country. I do actually do quite a bit of work in mental health systems here in Washington, DC, and access to mental healthcare for children. And

we are seeing that here, too.

I think, in terms of recovery, I think we can recover. We know that children both thrive with safe, stable, and nurturing relationships. We know that, with good supports, they can recover. And I think it's incumbent on us now to make sure we are putting those supports in place to make sure our children get the things they need to address—to address all the concerns that have risen here today.

Mr. Peters. Dr. Evans, I'd ask you to respond to the same general question. Has the pandemic affected the development of our children from a mental health and behavioral standpoint, and

whether we know if this is a long-lasting problem?

Dr. EVANS. Yes. Well, we know that the pandemic has had a big effect, but, you know, one of the things I want to stress is that it's not just the pandemic. We talk about a syndemic, because we have the financial, the political, the racial justice issues that have been raised, particularly for Asian Americans who have been discriminated against, and African Americans who experienced the summer last year. So it's a number of things that are impacting on children.

And the one thing that we know, number one, is that children are resilient. Children are going to be able to bounce back, but we, as adults, have to do and implement policies that help that to hap-

pen.

We believe that we have to take a comprehensive public health, population health approach. We have to have effective and efficient clinical services for children who are experiencing significant problems, but we also have to move beyond that and start looking at

children who are at risk.

We know who the children in our communities are who are at greater risk for having behavioral health challenges. The problem with the way we have dealt with behavioral health is that we wait until those children have crises before we intervene. We have to have more funding and more resources to identify those children early on and to intervene in ways to reduce the risk, or at least to intervene early.

And then, finally, we have to make sure that we are doing everything we can to build resilience in children, keeping children healthy and safe. We know from a lot of psychological research what are the factors that are related to psychological health. We need to make sure that teachers understand that. We need to make sure that we have programs like programs that build resiliency in children to do that.

So—and one other thing that I think is really important. We know from studies that look at disasters like 9/11 or hurricanes that, for children, the symptoms may last from 1 to 4 years. But the other thing we have to realize with children is that the kinds of harm that is happening really affect the trajectory of their lives, and we really need to be thinking longer than 4 years in terms of our sustained efforts at addressing their needs. And so that means

we need to be building the infrastructure today.

I'm very concerned that we are using one-shot temporary funding when what we should be doing today is building the infrastructure in the workforce and the infrastructure in programs that will last over the course of how these children will experience these problems over the next several years.

Mr. Peters. Doctor, let me follow up on that, because what I'm interested in is, you say we should direct more funding to this issue for early kind of intervention and support. What would be the infrastructure that we would fund? Does that exist today? Is there existing sort of things we should be funding or would we have to create something new for that?

Dr. EVANS. I think it's both. There are existing early intervention and prevention programs, but we don't have nearly enough of those

resources.

You know, I was a mental health commissioner for many years, and in most systems around the country, 95 percent of the services dollars that commissioners like myself have are directed at treatment. Treatment, by definition, is a reaction to something that's already happened.

If we really want to get ahead of this, we have to have more resources for prevention, early intervention. We have to get upstream. And one of the big problems with the way we've dealt with children's mental health in particular is it is very reactive. If you ask the typical parent about getting their child—

Mr. PETERS. Doctor, my time is expired. My time is expired. I appropriate that years much

preciate that very much.

And, Madam Chair, I yield back.

Ms. DEGETTE. I so appreciate that, Dr. Evans. And this committee, several years ago, had many, many hearings on pediatric mental health, and we welcome your continued involvement because we do need to get ahead of it.

And, Mr. Joyce, you've been very patient. I now recognize you for 5 minutes.

Mr. JOYCE. Thank you, Madam Chair, and thank you for convening this very important topic today.

I'm going to ask some very succinct questions for Dr. Hoeg, to start. Dr. Hoeg, do you feel that masks and using masks on kids

in school stops the spread of COVID-19?

Dr. Hoeg. So I think we need to look at the science that we have, and we need to admit that we don't have robust science or randomized control trials on this topic, but we have observational studies, one from the schools of the COVID response dashboard in Florida not finding an impact across mask mandates on teachers and students, and then from the CDC in Georgia not finding an impact of cloth mask mandates on children in terms of disease spread.

And so we need to recognize that masks may be providing a false sense of security or we're not potentially detecting the impact that they're having. So that remains an unknown until we have better

studies.

We have a randomized clinical trial from Bangladesh now that found surgical masking among adults can protect adults over 50 years old in the context of also increased distancing. But cloth masks in that study did not have any detectible impact in terms of SARS-CoV-2 rates in adults.

Mr. JOYCE. Dr. Hoeg, do you feel that isolating and quarantining children affects mental health and increases mental health issues

like anxiety and suicide in children?

Dr. HOEG. Yes, I do. I believe that, you know, from what I have seen, that we've watched children—a rise in the rates of mental health disorders coincide with keeping children in remote learning. And so children are, by nature, social creatures, and by disrupting this we're taking a major chance with their mental health, so-

Mr. JOYCE. And finally, Dr. Hoeg, do you feel that the large spike in BMI that we're seeing in children, especially kids ages 5 to 11, are we facing future long-term impact in pediatric health?

Dr. Hoeg. Oh, absolutely. So we saw a doubling of the increase of BMI among 3-to-11-year-olds. They were the most highly impacted in the study released by the CDC, and weight during childhood and obesity during childhood has enormous impacts on health later—later in life.

Mr. JOYCE. Thank you for those answers.

I'd like to turn to Dr. Beers. According to data from the CDC, early in the COVID-19 pandemic, the total number of emergency department visits related to child abuse and neglect slightly decreased, but the percentage of such visits resulting in hospitalizations increased in comparison to 2019. We've also seen reports of increased depression and anxiety in children and teens.

Could you comment on the potential missed and unreported cases in these increases in mental health problems among children, and do you think that the rise in these issues can be attributed to

the disruption of children in-person attending of school?

Dr. BEERS. Yes. So—yes, thank you. These are absolutely things we're concerned about. And I do think that the lack of in-person school for many children was a contributing factor. It's one of many factors, and I think it's important to recognize it is why the AAP very early on in the pandemic in our guidance, return-to-school guidance, said that we thought it was the highest priority for children to get back to school safely and to do that with layered, mitigated precautions so that they could.

Mr. JOYCE. And thank you for making that statement clear, that the American Academy of Pediatrics advocated for the rapid return

of kids to school.

Dr. Beers, you made a statement—and I share your concern—regarding missed routine vaccines for kids. And I've been working with my colleague present here today, Dr. Kim Schrier, another pe-

diatrician, in addressing that issue.

And, finally, in my remaining time, I really want to acknowledge, Dr. Beers, that your expertise as a pediatrician and as the president of the American Academy of Pediatrics is so important. But I also want to acknowledge something that some people might not know about you in this room, and that is your training at the Portsmouth Naval Hospital and your support of the United States military and their children at Gitmo in Cuba, at the National Medical Center here in Bethesda.

I worked at Portsmouth Naval Hospital during Desert Storm and Desert Shield, and I saw the hard-working military physicians caring for the children and caring for all the individuals there. I want to acknowledge that in the few minutes that I had remaining.

Thank you, Madam Chair, and I yield. Ms. DEGETTE. I thank the gentleman.

The Chair now recognizes Ms. Schrier for 5 minutes.

Ms. Schrier. Thank you, Madam Chair.

As the only pediatrician ever elected to Congress, this discussion about COVID and children is extremely important to me.

Dr. Beers, thank you for being here today. Thank you to all of

our witnesses.

You know, when COVID first hit, data from abroad and here in the United States suggested that children were really only minimally affected by the disease, and the primary reason for closing schools then was their role in transmitting disease to others. But with the highly contagious Delta variant, some children hospitals' ICUs are now full.

So, Dr. Beers, some quick questions for you. Do children get severe disease from COVID?

Dr. Beers. Yes, they definitely can.

Ms. Schrier. And Dr. Rush just told us a heartbreaking story about Sophia, who contracted COVID at school, gave it to her parents, both of whom tragically perished from the disease.

Can children spread this disease to others?

Dr. BEERS. Yes, they can. In fact, the CDC estimates that almost 120,000 children have lost a primary caregiver to COVID.

Ms. Schrier. Oh, my goodness. Do children get long COVID?

Dr. BEERS. Yes, children can get long COVID. We're still learning more about that, but they definitely can get it, and it can be very impactful on their lives.

Ms. Schrier. Can you just list a couple of the primary symptoms that they get so people understand how severe long COVID poten-

tially is?

Dr. Beers. Yes, absolutely. They can have cardiac heart symptoms, they can have persistent lung systems, neurologic symptoms where they, you know, have trouble thinking, and many of them have really debilitating fatigue and dizziness where they have difficulty standing up and going about their daily lives and going to school.

Ms. Schrier. And we don't even know how long that will last. So have rates of COVID in children increased with the start of the school year?

Dr. Beers. Yes, we definitely have been seeing more COVID.

Ms. Schrier. And that difference is different in different parts

of the country.

What would you say has distinguished schools where there has been lots of transmission from schools where there has not been lots of transmission, since masks have been a very contentious topic today?

Dr. BEERS. Yes, absolutely. And I think there's really two big things. One is the immunization rates in the community and the school as a contributing, and the other is the presence of the layered mitigated factors that schools implement, so things such as masking, distancing, hand washing, you know, testing, things like that.

Ms. Schrier. Thank you. I would also note just for clarification, there is a difference between cloth masks, KN95s, and surgical masks, in response to some of my colleagues. I would also mention that studies done with previous iterations of the virus are different from the current Delta information.

So, in your opinion, given a high number of children who are asymptomatic and still test positive for COVID, is there a role for surveillance testing in schools to keep infectious children home

when they can spread it to others?

Dr. BEERS. Yes, I do think so. I think, you know, this is one of the things we talk about as one of our layered precautions in schools, and surveillance testing can be a really important part of this sort of overall group of precautions to keep children in school safely as much as possible.

Ms. Schrier. Now, just to go down that path, what happens

when a child in a classroom tests positive?

Dr. BEERS. Oh, gosh. They have to go home, of course. We hope that they remain well and don't need to be hospitalized, as most children that will be the case. But they do need to be home for 10 to 14 days.

Ms. Schrier. So best-case scenario, they're home for 10 days, which means their parents are home with them for 10 days, 10 days of missed work.

Now, what about all the people next to them, the close contacts? I met with a school principal who has the job of contact tracing. What happens to all of those kids?

Dr. BEERS. Yes. It varies a little bit, depending on whether or not students are wearing masks and whether or not they're vaccinated. But they can need to be home for up to 7 to 14 days if they're unvaccinated and not consistently masking.

Ms. Schrier. So we could have multiple children home, and in middle schoolers and high schoolers, we go to many children at

home because they're in multiple classes per day.

So as we're talking about all of these kids potentially being home just in case, we talked about test-to-stay policies. In fact, that was one of the things that Dr. Hoeg talked about. Some schools, including now L.A. schools, have a policy where if one person in a classroom is positive, those around that person, instead of being asked to stay home for 14 days, actually can just be tested—the whole classroom could be tested every day and they could stay in, masked and with all other safety precautions.

What do think about that test-to-stay policy and what that

means for children?

Dr. BEERS. Yes. I think that can be a really effective strategy to help make sure children are in school as much as possible. Again, it has to be in the context of other important strategies, including vaccination and, at least for right now, masking. But testing can really help us keep our kids in school.

Ms. Schrier. Last super-quick question. We have heard a lot about mental health in kids. If we want our kids' mental health to be good, we need to keep them in school. What are the most important things we can do to make sure we keep kids in school to pro-

tect their mental health?

Dr. BEERS. Vaccinate anyone who is eligible and wear masks when you are in school.

Ms. Schrier. Thank you. I yield back.

Ms. DEGETTE. I thank the gentle lady. It takes a pediatrician to cut to the core. We appreciate it.

The Chair is now pleased to recognize Mrs. Trahan for 5 minutes.

Mrs. TRAHAN. Thank you, Madam Chair.

Ms. Danielpour, I, first of all, have to thank you for joining us today. I'm so impressed with your composure and your poise. Not every college freshman is ready to testify in front of Congress, let alone answer our questions, so thank you.

In your testimony, you mentioned your fear of infecting others, and I think a lot of younger Americans feel that same way. You know, my daughters, who are much younger than you, 7 and 11, in fact, they share that fear. You know, can they visit Nanny and Papa? Will they get sick as a result of that visit?

So restrictions, social distancing, wearing a mask, no one likes it, but we all have a responsibility to keep our families, our communities, and our children safe. So I thank you, and I will come back

I want to first start with Dr. Beers. I don't think it can be emphasized enough, especially in this venue, in this hearing: Can you just speak to the science supporting children wearing masks to slow the spread of COVID?

Dr. Beers. Yes, absolutely, I'd be happy to. You know, this is one of these areas that our expert group reviewed for interim guidance. They reviewed hundreds of studies actually from a variety of different types of studies and in a variety of different settings, and really the science is robust. And we are seeing actually this in action in schools, where schools who have implemented strong mitigation policies have much lower rates of COVID than schools who have not implemented universal masking.

I think some recent examples are a study—saw a couple studies in MMWR, from Florida, another from Georgia. There was another big group out of North Carolina that saw the same thing. So it really is—it's strong, robust evidence.

Mrs. Trahan. So while, you know, inconvenient: one, effective, and, two, it really does cut down on the anxiety I see in my own children in terms of their [inaudible] spread to others in the community or to their loved ones, their grandparents. So I appreciate that.

It's commendable that in just 9 months, more than 385 million doses of COVID vaccines have been administered and more than 181 million adults and youth as young as 12 years old are fully vaccinated in our country. Unfortunately, this still represents only 65 percent of eligible Americans nationwide, leaving millions of children at risk of serious infection.

Back in May, news broke of an unvaccinated elementary teacher in California who took her mask off to read to students and ended up infecting more than half of the classroom. So CDC Director Dr. Walensky said that the situation is a prime example of how easy it is to undermine efforts to protect children too young to be vaccinated.

Dr. Beers, your testimony stresses that, quote, "vaccines are the key to dramatically decreasing the spread of the virus and allowing children to return to a more normal semblance of life," which is what we all want.

Why is it important for the health of ineligible children that their older peers and adults get the vaccine, and how does this help sup-

port safe schools as students return to the classroom?

Dr. BEERS. Yes, thank you for that. You know, as we've discussed right now, children under the age of 12 don't have any access to vaccine, and even when, I think, we're hopeful that we will have a vaccine for 5-to-11-year-olds, we'll still have much younger children who are not yet eligible.

And so we know children—you know, anyone, you get COVID because you're exposed to it, and vaccinated adolescents and adults have significantly, significantly lower rates of being infected with

COVID.

And so when the adults in a child's life are vaccinated, that significantly decreases their exposure to COVID and significantly decreases the likelihood that they will get infected as well.

Mrs. Trahan. Great.

And, Ms. Danielpour, your voice in this conversation is so important. We know youth ages 12 to 18 have the lowest vaccination rate of any age group. Why do you think the vaccination rate is so low among teens?

Ms. Danielpour. Thank you for your kind words. I think there are several issues. Obviously, there are groups that falls into two camps. You have the first group which are young people who do want to be vaccinated are facing barriers in doing so, whether that is that they need a parent present who perhaps doesn't have childcare for siblings or cannot get time off work while a clinic may be open.

They have issues to access, as well as I think there are also for those who need to be convinced, I think it is understandable that people have fears and concerns about vaccines, but clearly they are

safe and effective.

I think a lot of it falls into there's—science is an evolving process, and so it's understandable that our messaging evolves too. But I do believe that there are—there's lots of confusion about whether a vaccine is necessary for a young person, how effective it is.

I also think that plays into the process of getting vaccinated, concerns about which vaccines work best, how many doses, based on [inaudible] and different side effects that fall into that, such as pu-

berty, fertility.

And I do believe [inaudible] increase confidence. I think, hopefully, FDA approval will do so. But I do think, speaking to the earlier point, there's something to be said at the beginning of the pandemic, we were told that young people really weren't at great risk of contracting the virus [inaudible]. I know everyone around me, those in our community were at risk.

And so I think [inaudible] answered, and I think there's very much a need for education, but I do think they recognize [inaudi-

ble] it's that we're all vaccinated—

Mrs. Trahan. Thank you so much to Ms. Danielpour. I asked you an unfair question to answer with so little time——

Ms. Degette. The gentle lady's time is expired. Mrs. Trahan. Thank you. I yield back.

Ms. DEGETTE. The gentle lady's time has expired, and I apologize

The Chair will announce that we've come to the fun part of the day when there's votes on the floor and we still have more Members who wish to ask questions. And our witnesses are doing great, so here's what we're going to do.

Mr. Griffith and I are going to go and vote and come back. Mr. Peters has miraculously appeared after voting. And we have Mr. O'Halleran, who is a member of this committee. Then we have three other Members who have waived on to this committee because this is such an important hearing, and we appreciate that, and so we will go to them.

And so, with that, I'm pleased to recognize Mr. O'Halleran for 5 minutes, and Mr. Peters will take the chair. Thank you.

Mr. O'HALLERAN. Thank you, Madam Chair.

We have heard quite a bit about COVID-19 vaccines today. I'm very hopeful that the FDA will soon issue an Emergency Use Authorization to make sure that children under 12 will be able to get that much-needed vaccination and protection.

In the meantime, I find it unacceptable that we are not doing everything to protect children, families, their teachers, and other school personnel as we return to in-person instruction, which I believe in. That has to be part of the process, to bring our children into the school environment.

Some States, like Arizona, have chosen to take many public health schools away from this process. The Governor is using federally allocated COVID-19 money, relief funds in fact, to further incentivize school districts to do away with public health best practices like masking. That would cost the school for each student \$1,800 per student, taking money actually away from the students' education. They're forcing school districts to choose between muchneeded school funding and the safety of children, teachers, and families.

I want to get to my questions here.

Dr. Beers, I had one question here, but what I'd like to ask you is, your vision for not now, not the rest of this year, maybe hopefully we get over this pandemic. What do you see that this committee continually has to do to be able to make sure that we know enough in the future to be able to make rational decisions that are hopefully in collaboration with our fellow Members?

Dr. BEERS. Well, thank you so much for that question. That's a wonderful question to answer, actually. I think, first and foremost, really always putting children at the center and making sure that children are our priority when we are making decisions. I think there's so many important reasons for that, and we're seeing, unfortunately, some of the problems that happen—that have arisen when that doesn't happen.

I think we do need to invest in evaluation and research, to make sure that we understand how to help children best, and I think investing in, as Dr. Evans said, investing in things for the long term, understanding that these things impact a children's lifetime, and they do need these services and supports for a lifetime—or for their childhood. And so really making sure that we're investing in longterm solutions and not just very short, short things.

Mr. O'HALLERAN. And these investments, would you say that they are critical to make sure that we will be able to be in a position to have the studies necessary to make better decisions if this

occurs again or when it occurs again?

Dr. BEERS. Yes, most definitely. This will help us, you know, have the supports and information that we need. I think it's also important, as Dr. Rush and others have noted, to support our children's hospitals, our pediatric healthcare delivery systems, our pediatricians, all of those who are doing this important work so that we can continue to respond and take care of children.

Mr. O'HALLERAN. And my last question to you, Doctor, by the way, is—because my other questions to others have been asked already—but beyond these basic measures that we've been discussing all day, have you seen any other creative strategies for helping to protect kids in school, and what else should schools be considering

today?

Dr. BEERS. Yes. I have actually seen some really wonderful and creative things, and I think, in my mind, this is one of the sad things about these really contentious debates we get into about some of the basic precautions, is that, as I said before, it distracts from really being able to dive in and do these important, innovative

things for our kids.

You know, there's outdoor schooling and there's, you know, band practice outside, and there's all sorts of, you know, really neat things that schools are doing, partnering with community-based agencies, you know, looking to, you know, like Ms. Danielpour said, looking to our teens and our youth for ideas. There's just millions of things we can be doing, and that's where I really hope we can focus our energies.

Mr. O'HALLERAN. Thank you, Doctor.

Thank you to the panel. And I just start to get to the point where we can work together as a body and protect the public safety of our citizens out there. Thank you very much.

I yield.

Mr. Peters [presiding]. We have now next in line Mr. Carter. Is Mr. Carter back? We have Mr. Carter.

The Chair now recognizes—take your time and get yourself settled—Mr. Carter for the purpose of asking questions for 5 minutes.

Mr. CARTER. Thank you, Mr. Chairman, and thank all of you for being here.

Dr. Beers, I want to start with you, if I may. The American Academy of Pediatrics' COVID-19 recommendations from the summer of 2020 stated that the risk of school closures was much greater than the health risk of the virus for children and that the social isolation could result in, and I quote, "sexual abuse, substance use, depression, and suicidal ideation," unquote.

You reiterated this in your written testimony, and you said, and

You reiterated this in your written testimony, and you said, and I quote, "the benefits of in-person school outweigh the risks in al-

most all circumstances," unquote.

In your experience, which is obviously extensive, in your experience, why did so many school districts ignore the recommendations

from the American Academy of Pediatrics and others to fully re-

open during the 2020–2021 school year?

Dr. BEERS. Well, thank you for that. Boy, I wish I knew the answer to that question in a lot of ways. I do want to emphasize, there's actually two aspects to that guidance, right? It is that it is incredibly important to open schools and do everything we can, and to do so in a way that keeps our students and our staff safe.

And I think actually what we saw is both ends of that spectrum where, you know, we had some schools reopening without those precautions, we had some schools not reopening. I think, you know, as to why, gosh, you know, there was a lot of fear, there was a lot of uncertainty. You know, I wish that we had been able to come together more and really rally around being able to open schools safely and do the right thing for our kids.

I think we can learn from looking back, but looking forward, I think we need to look forward and make sure we're continuing to

do the right thing for our kids.

Mr. CARTER. OK. Fair enough. As you know, Dr. Beers, a Freedom of Information Act request obtained emails between the CDC and the teachers union and some officials that revealed that the CDC had worked with the American Federation of Teachers on their school reopening guidance that was released in February of 2020.

At a time when every teacher in the country was eligible for the vaccination, in at least two instances that we're aware of, the union's suggestions were incorporated into the guidance.

Did the CDC consult with the Academy of American Pediatrics

before the guidance was released?

Dr. BEERS. Yes. You know, we have a very nice relationship with the CDC, actually, and talk very regularly, and I think we learn from their experts, they learn from ours. We do have good communication and collaboration. I don't know that I can speak to those emails, though.

Mr. CARTER. That's fine. I'm sure you do have a good relationship, but that wasn't the question. The question was, did the CDC consult with the Academy of American Pediatrics before the guid-

ance was released?

Dr. Beers. Yes. I think, you know, we talk with them on a really regular basis and share information on a really regular basis. So I think, you know, weekly we're talking to each other and sharing information, so I would—you know, I think we take each other's expertise into account all the time.

Mr. CARTER. OK. Is that a yes or a no?

Dr. BEERS. I think I can only assume that they took our expertise into account because we talk so regularly, but—

Mr. CARTER. And on the other hand, I would assume that they didn't because they didn't follow it.

OK. Dr. Hoeg and Dr. Beers—I'm not going to leave you alone yet—do you think that there was any scientific reason—any scientific reason—that children shouldn't have been in the classroom last semester?

Dr. HOEG. All right. I don't think that there was, on a broad scale, scientific reason that we should have been keeping children

out of school longer based on the results of our study and MMWR

and the results of the North Carolina-Duke study.

Yes, there was flip-flopping at that time from the messaging that we were getting that, you know, Dr. Fauci was saying we really need to get kids back in school, schools are safe based on these studies. And then the CDC sort of walked back on that. And, you know, I actually wasn't involved in the emails with the teachers' unions, but it was a bit—from my observation, it was a confusing point as to why they changed their recommendations.

Mr. CARTER. OK. Doctor, while I have you, I want to move very quickly because I have little time left. But are you aware of any studies on the impact of wearing a mask that has on—on the impact that wearing a mask has on children, particularly those in

kindergarten through fifth grade?

Dr. Hoeg. In terms of preventing COVID or in terms of other impacts?

Mr. CARTER. Other impacts. And preventing COVID. Both.

Dr. HOEG. So, again, in terms of preventing COVID, we really only have observational and not randomized studies with children, and we have not found the masking mandate of children have an

impact on COVID.

Ând then in terms of the negative impacts of masking, we need better studies on that. But, again, Europe has—Scandinavia has not masked under the age of 12 because they need proof that it works. And we've taken the opposite approach saying, you know, the precautionary that we will mask them until we find evidence that we don't need it, so—

Mr. CARTER. But you do agree that there are some other side effects that could happen because of mask mandates on children?

Mr. Peters. The gentleman's time is expired.

You want to answer that question?

Dr. Hoeg. Yes.

Mr. CARTER. Thank you. Mr. PETERS. Very quickly.

Dr. HOEG. So, obviously, there's a reason we don't all wear masks all day every day. So one can—you know, there's the benefit of seeing people smile and being comfortable without a mask on.

I mean, those I think are pretty obvious.

In terms of serious side effects, I think we need more—we would need more research before we said yes or no.

Mr. CARTER. OK. Thank you, Dr. Hoeg, Dr. Beers.

Mr. Peters. Thank you very much.

Mr. CARTER. And thank you, Mr. Chairman, for your indulgence.

Mr. Peters. Thank you very much.

We now recognize—the Chair now recognizes Mr. McNerney for the purpose of asking questions for 5 minutes.

the purpose of asking questions for 5 minutes.

Mr. McNerney. Well, I thank the Chair. And I thank the panel for this discussion this morning.

Dr. Beers, we heard this morning that children are 20 times more likely to get infected outside of school than in school. Is this a widely accepted statistic?

Dr. BEERS. Yes. I mean, I think that was one study, but, yes, I do believe that—or I do think and I agree that children are more likely to get infected with COVID in community-based settings.

Mr. McNerney. All right. Thank you.

Throughout this pandemic, we've championed healthcare providers on front lines. As we entered a new phase of the pandemic and face another surge due to the Delta variant, it has become even clearer that those who care for our children play a crucial role

in this fight.

Dr. Rush, as president of the children's hospital in Tennessee, you have an important, on-the-ground view of how this latest surge is affecting children, caregivers, and healthcare providers. Your testimony notes that in recent weeks the number of children hospitalized for COVID–19 has tripled in Children's Hospital.

Can you give us a sense of what children's hospitals like yours across the country are experiencing now that we have a sudden increase in demand? What are the trends as well as for beds and

staffing? Thank you.

Dr. Rush. Thank you for that question. So throughout the first three surges, most children's hospitals set up COVID units, anticipating that we would also have higher numbers of hospitalized children within our environment.

We have sustained a COVID unit dedicated in our hospital for children, and I would say for most of the time, we have averaged a daily census of two to four patients. That went up in the third

surge that began in November and really ended in January

With children, as I think we've talked about a little bit today, there are two waves to hospital admissions. The first may be with the acute illness. The majority of children, but not all that are hospitalized, may have an underlying condition: diabetes, obesity, cancer, congenital heart disease. But they also, the healthier children, may have a second wave where they become ill with a multi-inflammatory syndrome in children, and those children absolutely require hospitalization. And about 25 percent of them require intensive care for a portion of their hospitalization.

With the onset of the Delta surge, because so many more children are simply just becoming infected, we are seeing more children. Our peak number prior to August of this year was 15. We actually had to open a second unit to hold COVID children. We had—our maximum number early September was 27 in our children's hospital, and a quarter of those were in intensive care, and at least half of those in intensive care were on alert for more than just support from a ventilator. They were on alert for cardio bypass technology that would support their organs that were failing.

So while it is a small number proportionately, proportionately what we know is the rate of hospitalization is not really different in the Delta surge. But because so many more children are in-

fected, more children are requiring hospitalization.

What has been hard for the healthcare workforce in children's hospitals is that we've been running at near capacity since spring. As public health measures were eased, children began to socialize and viruses that normally infect children appeared to infect children offseason. And so we've been full all summer with what we in pediatrics traditionally think of as winter and fall viruses. So we've layered on top of a full capacity the COVID-19 Delta surge.

Our staff retired. We have run at full capacity now for 6 months,

beyond full capacity at times.

And as I stated earlier, the third disease that we have is our behavioral health disease. I have consistently had equally if not more numbers of children admitted to my hospital in the last 6 weeks with a behavioral health primary diagnosis as I have COVID.

Mr. McNerney. Thank you. Well, throughout this pandemic, we've lauded healthcare workers as heroes, and this is no less true today than it was a year ago. Yet the critical workforce continues to work under increasingly demanding and stressful circumstances.

Consequently, I'm very pleased that this committee recently passed provisions in the Build Back Better Act to invest in public health and mental health workers. But it's not clear—but it is clear that we need to continue to seek ways to invest and support the Nation's healthcare workforce.

Thank you, panel. And thank you, Chair, and I yield back.

Mr. PETERS. Thank you.

I want to thank the witnesses for your participation in the hearing today. I know it takes a lot of work to prepare for this. It takes a lot of stamina to sit through it. But your testimony before us is invaluable to us as we try to make the policy decisions that we make with the best information possible.

So thank you, Dr. Hoeg, Dr. Beers, Dr. Rush, Dr. Evans, and

Kelly Danielpour for your work on VaxTeen.

I would like to remind Members that, pursuant to the committee rules, we have—you have 10 business days to submit additional questions for the record to be answered by witnesses who have appeared before the subcommittee. I ask that the witnesses agree to respond promptly to any such questions should you receive any.

And Dr. Burgess has asked that we insert in the record, by unanimous consent, an article from The Wall Street Journal dated Sep-

tember 14, 2021.

Without objection, that is ordered.

[The information appears at the conclusion of the hearing.] Mr. Peters. With that, the subcommittee is adjourned. [Whereupon, at 1:08 p.m., the subcommittee was adjourned.] [Material submitted for inclusion in the record follows:]

## PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Thank you, Madame Chair, for holding this important hearing today. As of September 9th, 28.9% of COVID-19 cases were pediatric cases, and there have been 5.3 million pediatric cases since the start of the pandemic according to the American Academy of Pediatrics.

Academy of Pediatrics.

Currently, Texas is amongst the highest in the nation for pediatric COVID-19 covid cases. We have hit record breaking case numbers at 50,000 in addition to staffing shortages and limited ICU beds at numerous Texas facilities. This is no

longer a virus that only affects adults.

Despite the increase in pediatric cases, most recently, my office is aware of hospitals that have lost up to 100+ employees due to the vaccine mandate. This is not unique to Texas as healthcare professionals everywhere have been quitting their jobs over the past few weeks due to the fear of being forced into receiving a vaccine, they do not believe is right for them. This is concerning. We need frontline workers now more than ever to take care of COVID-19 patients, especially children.

COVID-19 is affecting children everywhere across America. However, children are not only being harmed by the virus itself, but the long-term effects from lockdowns

are also presenting serious consequences.

We have seen an unprecedented increase in behavioral and mental health issues in children over the past year. According to a study published by the CDC, emergency rooms have seen a 24 percent increase in mental health-related visits from

children ages 5 to 11 compared to last year, and an increase of emergency visits among older kids at 31 percent.

While we continue to learn about this virus, it is equally important that we ad-

dress potential solutions to prevent child covid cases, hospitalizations, and deaths. We know that mandates don't work and often have the opposite effect. Educating and encouraging parents to consult with their doctor has proven to be an effective way to tackle vaccine hesitancy.

However, there must be additional ways that we can address preventative safety

measures within schools to reduce the number of infections, without jeopardizing in-

person learning
All our districts have been hit hard by this virus. This is not a partisan issue. This hearing serves as an opportunity to hear from physicians and experts on how we can improve outcomes in pediatric COVID-19 cases.

Thank you all for being here today, and I look forward to our discussion.

# Facebook Knows Instagram Is Toxic for Teen Girls, Company Documents Show

Its own in-depth research shows a significant teen mental-health issue that Facebook plays down in public

*By* Georgia Wells

Jeff Horwitz and Deepa Seetharaman

Sept. 14, 2021 7:59 am ET

About a year ago, teenager Anastasia Vlasova started seeing a therapist. She had developed an eating disorder, and had a clear idea of what led to it: her time on Instagram.

She joined the platform at 13, and eventually was spending three hours a day entranced by the seemingly perfect lives and bodies of the fitness influencers who posted on the app.

"When I went on Instagram, all I saw were images of chiseled bodies, perfect abs and women doing 100 burpees in 10 minutes," said Ms. Vlasova, now 18, who lives in Reston, Va.

Around that time, researchers inside Instagram, which is owned by Facebook Inc., were studying this kind of experience and asking whether it was part of a broader phenomenon. Their findings confirmed some serious problems.

A LOOK INSIDE THE FACEBOOK FILES

Our reporters will discuss their findings from the WSJ's Facebook Files investigation. <u>Ask your questions now</u> and join them for a live Q&A at 1 p.m. ET Monday.

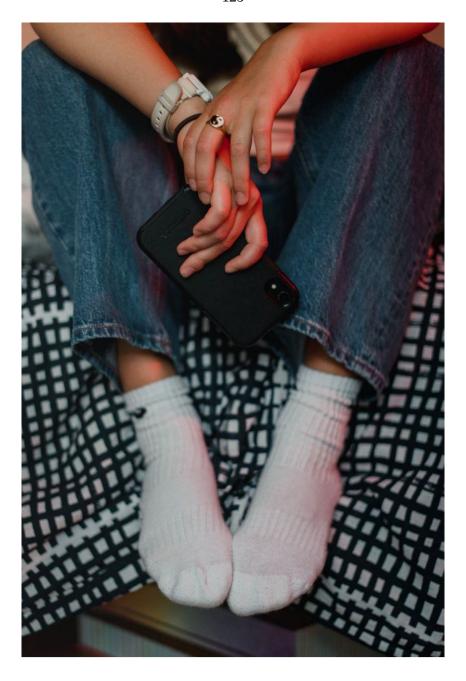
"Thirty-two percent of teen girls said that when they felt bad about their bodies, Instagram made them feel worse," the researchers said in a March 2020 slide presentation posted to Facebook's internal message board, reviewed by The Wall Street Journal. "Comparisons on Instagram can change how young women view and describe themselves."

For the past three years, Facebook has been conducting studies into how its photosharing app affects its millions of young users. Repeatedly, the company's researchers found that Instagram is harmful for a sizable percentage of them, most notably teenage girls.

"We make body image issues worse for one in three teen girls," said one slide from 2019, summarizing research about teen girls who experience the issues.

"Teens blame Instagram for increases in the rate of anxiety and depression," said another slide. "This reaction was unprompted and consistent across all groups."

Among teens who reported suicidal thoughts, 13% of British users and 6% of American users traced the desire to kill themselves to Instagram, one presentation showed.



Ms. Vlasova traced her eating disorder to Instagram. PHOTO: HANNAH YOON FOR THE WALL STREET JOURNAL

Expanding its base of young users is vital to the company's more than \$100 billion in annual revenue, and it doesn't want to jeopardize their engagement with the platform.

More than 40% of Instagram's users are 22 years old and younger, and about 22 million teens log onto Instagram in the U.S. each day, compared with five million teens logging onto Facebook, where young users have been shrinking for a decade, the materials show.

On average, teens in the U.S. spend 50% more time on Instagram than they do on Facebook.

"Instagram is well positioned to resonate and win with young people," said a researcher's slide posted internally. Another post said: "There is a path to growth if Instagram can continue their trajectory."

In public, Facebook has consistently played down the app's negative effects on teens, and hasn't made its research public or available to academics or lawmakers who have asked for it.

"The research that we've seen is that using social apps to connect with other people can have positive mental-health benefits," CEO Mark Zuckerberg said at a congressional hearing in March 2021 when asked about children and mental health. In May, Instagram head Adam Mosseri told reporters that research he had seen suggests the app's effects on teen well-being is likely "quite small."

In a recent interview, Mr. Mosseri said: "In no way do I mean to diminish these issues....Some of the issues mentioned in this story aren't necessarily widespread, but their impact on people may be huge."

### THE FACEBOOK FILES

Want an email alert for the next article in the Journal's <u>Facebook</u>
<u>Files</u> investigation? <u>Sign up here</u> and also get email alerts for major tech sector news in the future.

He said he believes Facebook was late to realizing there were drawbacks to connecting people in such large numbers. "I've been pushing very hard for us to embrace our responsibilities more broadly," he said.

He said the research into the mental-health effects on teens was valuable, and that Facebook employees ask tough questions about the platform. "For me, this isn't dirty laundry. I'm actually very proud of this research," he said.

Some features of Instagram could be harmful to some young users, and they aren't easily addressed, he said. He added: "There's a lot of good that comes with what we do."

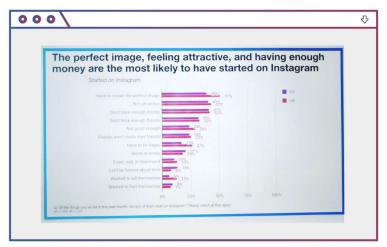
# What Facebook knows

The Instagram documents form part of a trove of internal communications reviewed by the Journal, on areas including teen mental health, political discourse and human trafficking. They offer an unparalleled picture of how Facebook is acutely aware that the products and systems central to its business success routinely fail.

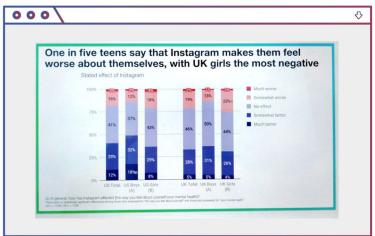
The documents also show that Facebook has made minimal efforts to address these issues and plays them down in public.

The company's research on Instagram, the deepest look yet at what the tech giant knows about its impact on teens and their mental well-being, represents one of the clearest gaps revealed in the documents between Facebook's understanding of itself and its public position.

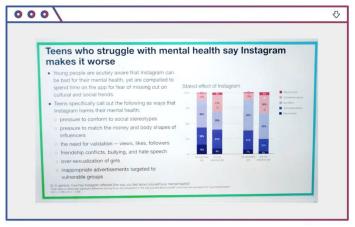
Its effort includes focus groups, online surveys and diary studies in 2019 and 2020. It also includes large-scale surveys of tens of thousands of people in 2021 that paired user responses with Facebook's own data about how much time users spent on Instagram and what they saw there.



from the files



from the files



from the files

Source: 2019 Instagram slide presentation called 'Teen Mental Health Deep Dive'

The researchers are Facebook employees in areas including data science, marketing and product development who work on a range of issues related to how users interact with the platform. Many have backgrounds in computer science, psychology and quantitative and qualitative analysis.

In five presentations over 18 months to this spring, the researchers conducted what they called a "teen mental health deep dive" and follow-up studies.

They came to the conclusion that some of the problems were specific to Instagram, and not <u>social media more broadly</u>. That is especially true concerning so-called social comparison, which is when people assess their own value in relation to the attractiveness, wealth and success of others.

"Social comparison is worse on Instagram," states Facebook's deep dive into teen girl body-image issues in 2020, noting that <u>TikTok</u>, a <u>short-video app</u>, is grounded in performance, while users on Snapchat, a rival photo and video-sharing app, are sheltered by jokey filters that "keep the focus on the face." In contrast, Instagram focuses heavily on the body and lifestyle.

The features that Instagram identifies as most harmful to teens appear to be at the platform's core.

The tendency to share only the best moments, a pressure to look perfect and an addictive product can send teens spiraling toward eating disorders, an unhealthy sense of their own bodies and depression, March 2020 internal research states. It warns that the Explore page, which serves users photos and videos curated by an algorithm, can send users deep into content that can be harmful.

"Aspects of Instagram exacerbate each other to create a perfect storm," the research states.

The research has been reviewed by top Facebook executives, and was cited in a 2020 presentation given to Mr. Zuckerberg, according to the documents.

At a congressional hearing this March, Mr. Zuckerberg defended the company against criticism from lawmakers about <u>plans to create a new Instagram product for children under 13</u>. When asked if the company had studied the app's effects on children, he said, "I believe the answer is yes."

In August, Sens. Richard Blumenthal and Marsha Blackburn in a letter to Mr. Zuckerberg called on him to release Facebook's internal research on the impact of its platforms on youth mental health.

In response, Facebook sent the senators a six-page letter that didn't include the company's own studies. Instead, Facebook said there are many challenges with conducting research in this space, saying, "We are not aware of a consensus among studies or experts about how much screen time is 'too much,' " according to a copy of the letter reviewed by the Journal.

Facebook also told the senators that its internal research is proprietary and "kept confidential to promote frank and open dialogue and brainstorming internally."

A Facebook spokeswoman said the company welcomed productive collaboration with Congress and would look for opportunities to work with external researchers on credible studies.

"Facebook's answers were so evasive—failing to even respond to all our questions—that they really raise questions about what Facebook might be hiding," Sen. Blumenthal said in an email. "Facebook seems to be taking a page from the textbook of Big Tobacco—targeting teens with potentially dangerous products while masking the science in public."

Mr. Mosseri said in the recent interview, "We don't send research out to regulators on a regular basis for a number of reasons." He added Facebook should figure out a way to share high-level overviews of what the company is learning, and that he also wanted to give external researchers access to Facebook's data.

He said the company's plan for the <u>Instagram kids product</u>, <u>which state attorneys</u> general have objected to, is still in the works.

When told of Facebook's internal research, Jean Twenge, a professor of psychology at San Diego State University who has published research finding that social media is harmful for some kids, said it was a potential turning point in the discussion about how social media affects teens.

"If you believe that R.J. Reynolds should have been more truthful about the link between smoking and lung cancer, then you should probably believe that Facebook should be more upfront about links to depression among teen girls," she said.

### Race for teen users

When Facebook paid \$1 billion for Instagram in 2012, it was a tiny startup with 13 employees and already a hit. That year, Facebook for the first time had observed a decline in the number of teens using its namesake Facebook product, according to the documents. The company would come to see Instagram as Facebook's best bet for growth among teens.

Facebook had been tracking the rise of buzzy features on competitor apps, including Snapchat, and in 2016 directed employees to focus on winning what they viewed as a race for teen users, according to former Instagram executives.

Instagram made photos the app's focus, with filters that made it easy for users to edit images. It later added videos, feeds of algorithmically chosen content and tools that touched up people's faces.

Before long, Instagram became the online equivalent of the high-school cafeteria: a place for teens to post their best photos, find friends, size each other up, brag and bully.

Facebook's research indicates Instagram's effects aren't harmful for all users. For most teenagers, the effects of "negative social comparison" are manageable and can be outweighed by the app's utility as a fun way for users to express themselves and connect with friends, the research says.



Destinee Ramos, left, and Isabel Yoblonski said the obsessive use of Instagram had potential health drawbacks.

PHOTO: LIANNE MILTON FOR THE WALL STREET JOURNAL

But a mounting body of Facebook's own evidence shows Instagram can be damaging for many.

In one study of teens in the U.S. and U.K., Facebook found that more than 40% of Instagram users who reported feeling "unattractive" said the feeling began on the app. About a quarter of the teens who reported feeling "not good enough" said the feeling started on Instagram. Many also said the app undermined their confidence in the strength of their friendships.

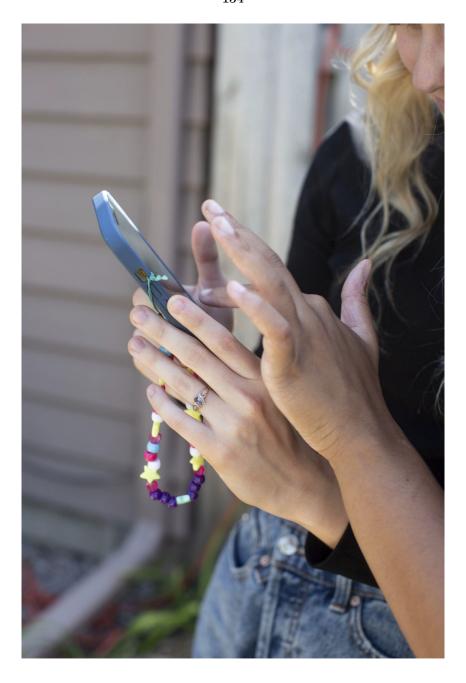
Instagram's researchers noted that those struggling with the platform's psychological effects weren't necessarily logging off. Teens regularly reported <u>wanting to spend less time on Instagram</u>, the presentations note, but lacked the self control to do so.

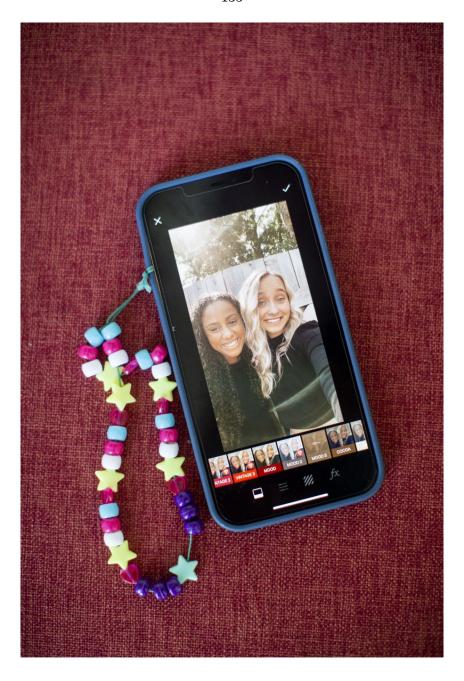
"Teens told us that they don't like the amount of time they spend on the app but feel like they have to be present," an Instagram research manager explained to colleagues, according to the documents. "They often feel 'addicted' and know that what they're seeing is bad for their mental health but feel unable to stop themselves."

During the isolation of the pandemic, "if you wanted to show your friends what you were doing, you had to go on Instagram," said Destinee Ramos, 17, of Neenah, Wis. "We're leaning towards calling it an obsession."

Ms. Ramos and her friend Isabel Yoblonski, 18, believed this posed a potential health problem to their community, so they decided to survey their peers as a part of a national science competition. They found that of the 98 students who responded, nearly 90% said social media negatively affected their mental health.







Ms. Yoblonski and Ms. Ramos took a selfie. PHOTOS: LIANNE MILTON FOR THE WALL STREET JOURNAL

In focus groups, Instagram employees heard directly from teens who were struggling. "I felt like I had to fight to be considered pretty or even visible," one teen said of her experience on Instagram.

After looking through photos on Instagram, "I feel like I am too big and not pretty enough," another teen told Facebook's researchers. "It makes me feel insecure about my body even though I know I am skinny."

"For some people it might be tempting to dismiss this as teen girls being sad," said Dr. Twenge. But "we're looking at clinical-level depression that requires treatment. We're talking about self harm that lands people in the ER."

# 'Kick in the gut'

Eva Behrens, a 17-year-old student at Redwood High School in Marin County, Calif., said she estimates half the girls in her grade struggle with body-image concerns tied to Instagram. "Every time I feel good about myself, I go over to Instagram, and then it all goes away," she said.

When her classmate Molly Pitts, 17, arrived at high school, she found her peers using Instagram as a tool to measure their relative popularity. Students referred to the number of followers their peers had as if the number was stamped on their foreheads, she said.

Now, she said, when she looks at her number of followers on Instagram, it is most often a "kick in the gut."

For years, there has been little debate among medical doctors that for some patients, Instagram and other social media exacerbate their conditions. Angela Guarda, director for the eating-disorders program at Johns Hopkins Hospital and an associate professor of psychiatry in the Johns Hopkins School of Medicine, said it is common for her patients to say they learned from social media tips for how to

restrict food intake or purge. She estimates that Instagram and other social-media apps play a role in the disorders of about half her patients.

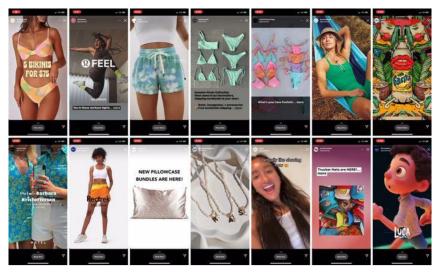
"It's the ones who are most vulnerable or are already developing a problem—the use of Instagram and other social media can escalate it," she said.

Lindsay Dubin, 19, recently wanted to exercise more. She searched Instagram for workouts and found some she liked. Since then the app's algorithm has filled her Explore page with photos of how to lose weight, the "ideal" body type and what she should and shouldn't be eating. "I'm pounded with it every time I go on Instagram," she said.

Jonathan Haidt, a social psychologist at New York University's Stern School of Business and co-author of the bestseller "The Coddling of the American Mind," has been concerned about the effects of social media on teens since he started studying it in 2015. He has twice spoken with Mr. Zuckerberg about Facebook's effects on teen mental health, the first time after the CEO reached out in 2019.

Mr. Zuckerberg indicated that on the issues of political polarization and teen mental health, he believed that the research literature was contradictory and didn't point clearly to any harmful causal effects, according to Mr. Haidt. He said he felt Mr. Zuckerberg at the time was "a partisan, but curious."

"I asked Mark to help us out as parents," he said. "Mark said he was working on it."



Lindsay Dubin found that in two minutes of watching Instagram stories, she saw 33 stories of accounts she follows as well as these 14 ads, many of which were focused on physical appearances.

In January 2020, Facebook invited Mr. Haidt to its Menlo Park, Calif., headquarters, where Mr. Mosseri and Instagram staff briefed him on the platform's efforts to combat bullying and reduce social pressure on the platform. Mr. Haidt said he found those efforts sincere and laudable but warned that they likely weren't enough to battle what he believes is a mounting public-health epidemic.

"It was not suggested to me that they had internal research showing a problem," he said.

The Facebook spokeswoman declined to comment on the interaction.

Some Instagram researchers said it was challenging to get other colleagues to hear the gravity of their findings. Plus, "We're standing directly between people and their bonuses," one former researcher said.

Instead of referencing their own data showing the negative effects of Instagram, Facebook executives in public have often pointed to studies from the Oxford Internet Institute that have shown little correlation between social-media use and depression.

Other studies also found discrepancies between the amount of time people say they use social media and the amount of time they actually use such services. Mr. Mosseri has pointed to these studies as evidence for why research using self-reported data might not be accurate.

Facebook has in the past been a donor to a researcher at the Oxford institute, which is part of the research and teaching department of Britain's Oxford University.

Oxford's lead researcher on the studies, Andrew Przybylski, who said he didn't receive funding from Facebook, said companies like Facebook need to be more open about their research. "The data exists within the tech industry," he said. "Scientists just need to be able to access it for neutral and independent investigation."

In an interview, Mr. Przybylski said, "People talk about Instagram like it's a drug. But we can't study the active ingredient."

A recent experience on Ms. Dubin's Explore page, which is filled with photos and videos curated by Instagram's algorithm.

Facebook executives have struggled to find ways to reduce Instagram's harm while keeping people on the platform, according to internal presentations on the topic.

For years, Facebook experimented with hiding the tallies of "likes" that users see on their photos. Teens told Facebook in focus groups that "like" counts caused them anxiety and contributed to their negative feelings.

When Facebook tested a tweak to hide the "likes" in a pilot program they called Project Daisy, it found it didn't improve life for teens. "We didn't observe movements in overall well-being measures," Facebook employees wrote in a slide they presented to Mr. Zuckerberg about the experiment in 2020.

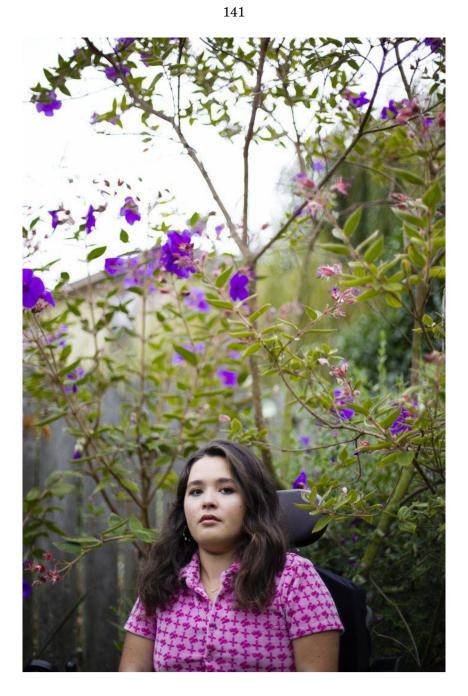
Nonetheless, <u>Facebook rolled out the change as an option</u> for Facebook and Instagram users in May 2021 after senior executives argued to Mr. Zuckerberg that it could make them look good by appearing to address the issue, according to the documents.

"A Daisy launch would be received by press and parents as a strong positive indication that Instagram cares about its users, especially when taken alongside other press-positive launches," Facebook executives wrote in a discussion about how to present their findings to Mr. Zuckerberg.

When Facebook rolled out Project Daisy, Mr. Mosseri acknowledged publicly that the feature didn't actually change much about how users felt.

In the interview, he said he doesn't think there are clear-cut solutions to fixing Instagram. He said he is cautiously optimistic about tools Instagram is developing to identify people who are in trouble and to try to "nudge" them toward more positive content.

Facebook made two researchers available to discuss their work. They said they are also testing a way to ask users if they want to take a break from Instagram. Part of the challenge, the researchers said, is they struggle to determine which users face the greatest risk. The researchers also said that the causality of some of their findings was unclear, and noted some of the studies had small sample sizes.



Sylvia Colt-Lacayo at her childhood home in Oakland, Calif., last month. PHOTO: TALIA HERMAN FOR THE WALL STREET JOURNAL

"I think anything and everything should be on the table," Mr. Mosseri said. "But we have to be honest and embrace that there's trade-offs here. It's not as simple as turning something off and thinking it gets better, because often you can make things worse unintentionally."

# Zeroed in on selfies

In the internal documents, Facebook's researchers also suggested Instagram could surface "fun" filters rather than ones around beautification. They zeroed in on selfies, particularly filtered ones that allow users to touch-up their faces. "Sharing or viewing filtered selfies in stories made people feel worse," the researchers wrote in January.

Sylvia Colt-Lacayo, a 20-year-old at Stanford University, said she recently tried out a face filter that thinned her cheeks and made them pink. But then Ms. Colt-Lacayo realized the filter had minimized her cheeks that she inherited from her Nicaraguan father, and made them look more European. That gave her "a bitter taste in my mouth," she said.

Ms. Colt-Lacayo uses a wheelchair, and in the past Instagram made her feel like she didn't look the way she was supposed to, or do the things that other teen girls on the app were doing, she said.



Ms. Colt-Lacayo's selfie, which she put through an Instagram filter. PHOTO: SYLVIA COLT-LACAYO

She said she began following people who use wheelchairs, or who are chronically ill or refer to other disabilities, and the platform became a place she could see images of older disabled people just being happy.

In March, the researchers said Instagram should reduce exposure to celebrity content about fashion, beauty and relationships, while increasing exposure to content from close friends, according to a slide deck they uploaded to Facebook's internal message board.

A current employee, in comments on the message board, questioned that idea, saying celebrities with perfect lives were key to the app. "Isn't that what IG is mostly about?" he wrote. Getting a peek at "the (very photogenic) life of the top 0.1%? Isn't that the reason why teens are on the platform?"

A now-former executive questioned the idea of overhauling Instagram to avoid social comparison. "People use Instagram because it's a competition," the former executive said. "That's the fun part."

To promote more positive use of Instagram, the company has partnered with nonprofits to promote what it calls "emotional resilience," according to the documents. Videos produced as part of that effort include recommending that teens consider daily affirmations to remind themselves that "I am in control of my experience on Instagram."

Facebook's researchers identified the over-sexualization of girls as something that weighs on the mental health of the app's users. Shevon Jones, a licensed clinical social worker based in Atlanta, said this can affect Black girls especially because people often assume Black girls are older than they are and critique the bodies of Black girls more frequently.

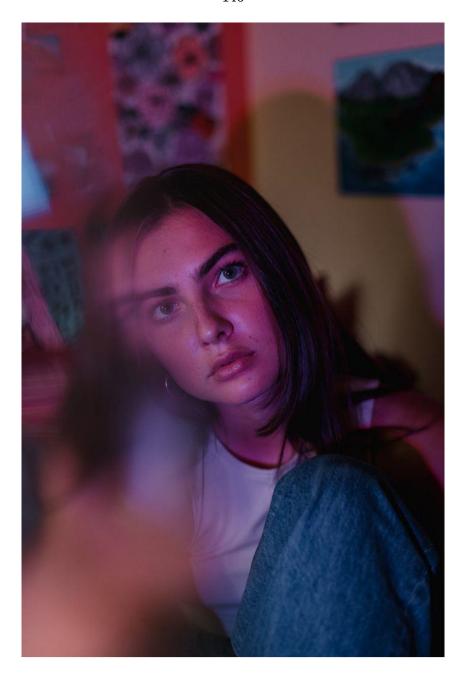
"What girls often see on social media are girls with slimmer waists, bigger butts and hips, and it can lead them to have body image issues," Ms. Jones said. "It's a very critical time and they are trying to figure out themselves and everything around them."

Teen boys aren't immune. In the deep dive Facebook's researchers conducted into mental health in 2019, they found that 14% of boys in the U.S. said Instagram made them feel worse about themselves. In their report on body image in 2020, Facebook's researchers found that 40% of teen boys experience negative social comparison.

"I just feel on the edge a lot of the time," a teen boy in the U.S. told Facebook's researchers. "It's like you can be called out for anything you do. One wrong move. One wrong step."

Many of the teens interviewed for this article said they didn't want Instagram to disappear. Ms. Vlasova, who no longer uses Instagram, said she is skeptical Facebook's executives have tried hard enough to make their platform less toxic.

"I had to live with my eating disorder for five years, and people on Instagram are still suffering," she said.



Ms. Vlasova said she no longer uses Instagram. PHOTO: HANNAH YOON FOR THE WALL STREET JOURNAL

—Design by Andrew Levinson.

## Attachment-Additional Questions for the Record

# Subcommittee on Oversight and Investigations Hearing on "Putting Kids First: Addressing COVID-19's Impacts on Children" September 22, 2021

Lee Savio Beers, M.D., F.A.A.P., President, American Academy of Pediatrics

## The Honorable Paul Tonko (D-NY)

1. I had the opportunity to tour the Monte Nido & Affiliates eating disorder treatment facility in New York in 2019. What I learned about this complex mental illness and the incredible work of the team there, is something I will never forget. The mental health of our nation's children is so critically important and it is devastating to see the mental health declines of this population. Understanding that one of the mental illnesses with a sharp rise is eating disorders is heartbreaking. The National Eating Disorders Association based in New York has seen a 40% increase in their helpline with 35% of callers between 13 and 17 years of age. Dr. Beers, can you help explain why we think this trend is occurring?

## Response

Thank you for that question. As you noted, pediatricians are seeing dramatic increases in eating disorders, a very complicated condition that requires multi-disciplinary treatment. My adolescent medicine and child psychiatry colleagues tell me that not only are they seeing many more cases of eating disorders, but they are more severe and are starting at even younger ages, even down to the age of 8 or 9, and that because of the complexity of the treatment for eating disorders, it is extremely difficult to access fully comprehensive care for patients.

As a result of the economic hardships and inconsistent access to school breakfasts and lunches because of virtual, half-day, and/or hybrid learning, many children and adolescents may not have had regular access to nutritious foods over the course of the pandemic. Families may have experienced shifts to high-calorie snack foods and nonperishable processed foods; there may have been significant increases in the consumption of unhealthy snacks and sugary sweetened beverages. Both food insecurity and food scarcity can negatively affect nutrition, lead to increased risk for disordered eating, and increase consumption of nonnutritive, calorie-dense foods that can lead to unhealthy weight gain and contribute to obesity.

Closures of recreational sports, gyms, and schools as well as important safety and mitigation measures related to reopening recreational activities and resuming organized sports and physical education have resulted in less access to opportunities for organized physical activities. In-person organized sports and physical education classes may be modified or limited because of physical distancing requirements and space issues in schools and recreational buildings. Families report

that during COVID-19 mitigation, time spent in physical activity and sports has decreased while sleep time and screen time have increased.

Mood disorders and experience of trauma can have impacts on eating and physical activity, and relatedly on the incidence of eating disorders. In the setting of the pandemic, changes in nutrition/weight may be indicators of more significant mental health issues. Mood disorders and other mental health concerns may interfere with the ability to promote a healthy lifestyle. It is uncertain what the impact of social media has been, however it is very plausible that increased use of social media over the pandemic has exposed youth to content that has exacerbated all of these issues

In sum, the coalescing of the impacts of the pandemic on nutrition, physical activity and mental health have created increased risk for pre-teens and teens of experiencing an eating disorder. For further information on addressing eating disorders, please refer to the Academy's Policy Statement <u>Identification and Management of Eating Disorders in Children and Adolescents</u>.

# The Honorable Scott H. Peters (D-CA)

1. It is clear that the covid pandemic has been harmful to the mental health of children for a variety of reasons, but even more so for foster children, who often have higher need for mental health services. As a result of the pandemic, mental health appointments, placement appointments, and other in-person activities were suspended or delayed, disrupting the routines of these vulnerable children. Across the country, including in my district in San Diego County, qualified residential treatment program (QTRP) facilities currently provide placement, educational, and supportive services, including mental health treatment, to youth experiencing foster care. QRTPs with more than 16 beds will soon be deemed to be "institutions of mental disorders" (IMDs) by the Centers for Medicare and Medicaid Services. This means congregate foster care facilities will be unable to receive Medicaid funding to care for these children. Can you talk about whether you agree with CMS that QRTPs are not IMDs in practice?

## Response

In recognition of the significant mental health crisis children and young people are currently facing, on October 19, the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national emergency in child and adolescent mental health. The COVID-19 pandemic and ongoing inequities around structural racism have exacerbated the mental health crisis that existed before the pandemic. AAP is encouraging policymakers at all levels of government to take swift action to ensure children and young people have access to critical supports to address this national state of emergency in mental health.

Certainly, children and young people in foster care have felt the weight of the mental health crisis compounded by the existing trauma of removal from their families. AAP has long advocated to keep children and families together whenever safe to do so, as the research is clear that children fare best in families. When that is not possible, it is paramount that children have access to family-based care where they are able to build critical connections that allow them to heal from their trauma and build resiliency. Therefore, AAP has long supported the *Family First Prevention Services Act* (Family First) and it's three fundamental principles: 1) Helping families remain safely together; 2) Ensuring children in foster care can live with family; and 3) Ensuring residential treatment programs provide trauma-informed services to address a demonstrated time-limited need that cannot be met in a family setting.

Family First made important changes to reform congregate care with the establishment of the Quality Residential Treatment Program (QRTP) model, which establishes safeguards to ensure children can receive appropriate, time-limited treatment that meet the child's needs and help them to reach permanency in a family-based setting. AAP strongly supports these reforms and has been concerned by the ongoing effort to create sweeping exemptions to the longstanding Medicaid Institutions for Mental Disease (IMDs) policy based on concerns about whether QRTPs will be considered IMDs. The IMD policy predates Family First, which did not make any changes to Medicaid law.

AAP opposes proposed legislation (S. 2689/H.R. 5414) that would create a categorical federal exemption from Medicaid law for all QRTPs. The Medicaid IMD exclusion generally prohibits Medicaid payments to facilities primarily providing mental health and substance use disorder treatment services if they have more than 16 beds. One of the reasons the IMD exclusion was created was to incentivize community-based services, with an understanding that large, restrictive institutions were counterproductive in mental health treatment. Decades of research and lived experience has shown the same is true in child welfare; children fare best in the least restrictive settings possible, preferably with families, and institutional placement is often traumatic and lacks the setting and supports to help a child to flourish.

AAP agrees that more progress is necessary to address the mental health needs of children and youth in foster care. We urge Congress to provide more supports for community-based trauma-informed mental health services for this population, to continue supporting high-quality kinship and non-relative family foster care, and and to continue prioritizing prevention services that ensure that fewer children come into foster care unnecessarily. These needed reforms would further reduce over reliance on congregate care and support the implementation of Family First.

2. As we discuss the impacts of covid-19 on children, I want to raise the issue of the surge in the serious mental illness of eating disorders among children. We've seen a 25% increase in adolescent hospitalizations due to eating disorders, and admissions at Children's Hospitals have doubled across the nation. Additionally, a recent analysis of the Suicide Lifeline found that callers with eating disorders were less likely to have resolved their suicidal ideations at

the end of the call, in comparison to callers presenting with depression. However, ED treatment availability is limited, creating a dire need for more access to care.

a. What can Children's Hospitals do to work to address the rise in eating disorders cases given the strain on treatment capacity?

#### Response

The pediatrician often is the first professional consulted by a parent or the school when there is a concern about a possible eating disorder (ED). Early diagnosis and intervention are associated with improved outcome. EDs are best evaluated and managed by a multidisciplinary health care team, with the pediatrician as an important member of that team. A thorough physical examination and review of systems can help to identify any underlying medical and psychiatric causes for weight loss.

EDs are the third most common chronic condition in adolescents, after obesity and asthma. The prevalence of childhood obesity has increased dramatically over the past few decades in the United States and other countries, and obesity during adolescence is associated with significant medical morbidity during adulthood. Most adolescents who develop an ED did not have obesity previously, but some adolescents may misinterpret what "healthy eating" is and engage in unhealthy behaviors, such as skipping meals or using fad diets in an attempt to "be healthier," the result of which could be the development of an ED. Messages from pediatricians addressing obesity and reviewing constructive ways to manage weight can be safely and supportively incorporated into health care visits. Avoiding certain weight-based language and using motivational interviewing (MI) techniques may improve communication and promote successful outcomes when providing weight-management counseling.

MI is defined as "a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." A study conducted through the AAP Pediatric Research in Office Settings (PROS) network assessed the effect of MI delivered by pediatricians and found that pediatricians and dietitians who used MI to counsel families with overweight children were successful in reducing children's BMI percentile by 3.1 more points than a control group in which MI was not used. Pediatricians can successfully facilitate their patients' lifestyle behavior changes. Concerns from pediatricians and parents that obesity counseling can lead to an ED can be addressed by understanding the effectiveness of family-centered MI to promote healthy behaviors. Continued support and training for pediatricians to use MI in this context, as well as on how to identify EDs and co-manage them as part of a multi-disciplinary team would be very useful and impactful.

Obesity prevention and treatment, if conducted correctly, does not predispose to EDs. On the contrary, randomized controlled trials of obesity prevention programs have shown a reduction in the use of self-induced vomiting or diet pill use to control weight and a decrease in concerns about weight in the intervention groups. Family involvement in the treatment of both adolescent obesity and EDs has been determined to be more effective than an adolescent-only focus. An

integrated approach to the prevention of obesity and EDs focuses less on weight and more on healthy family-based lifestyle modification that can be sustained.

Pediatricians can encourage parents to be healthy role models and supportively manage the food environment by creating easy accessibility to healthy foods (eg, fruits, vegetables, whole grains, beans and other legumes, and water) and by limiting the availability of sweetened beverages, including those containing artificial sweeteners, and other foods containing refined carbohydrates. Discussions between pediatricians and parents about increasing physical activity and limiting the amount of total entertainment screen time to less than 2 hours/day are important and may lead to changes in family behavior. Another area of prevention is avoiding the presence of a television in the teenager's bedroom, because having a television in the room predicts significantly less physical activity as well as poorer dietary intakes compared with not having a television in the room. Other evidence-based approaches encourage parents to include more family meals, home-prepared meals, and meals with less distractions as well as fewer discussions about weight and about dieting. Understanding that poor body image can lead to an ED, parents should avoid comments about body weight and discourage dieting efforts that may inadvertently result in EDs and body dissatisfaction. Children's hospitals can help support the pediatricians in their community to do this essential health promotion work that can decrease the incidence of EDs through providing education and training, consultation and facilitating collaborative partnerships that increase access to healthy foods and safe physical activity.

b. What additional resources are needed to adequately treat eating disorders in children and adolescents?

## Response

Efforts to prevent eating disorders can take place both in practice and community settings, such as schools. A variety of successful programs for preventing eating pathology have been developed for various settings. While treating disordered eating, it is also important to address the mental health challenges that may be co-occurring in the child or adolescent. More federal resources must be dedicated to ensuring all families and children, from infancy through adolescence, can access evidence-based mental health screening, diagnosis, and treatment to appropriately address their mental health needs, with particular emphasis on meeting the needs of under-resourced populations. This includes fully funding comprehensive, community-based systems of care that connect families in need of behavioral health services and supports for their child with evidence-based interventions in their home, community or school.

<sup>&</sup>lt;sup>i</sup> Golden NH, et al. Preventing Obesity and Eating Disorders in Adolescents. *Pediatrics*. 2016; 138 (3): e20161649.





October 26, 2021

The Honorable Frank Pallone Chairman House Committee on Energy and Commerce Via electronic submission to Austin Flack, Policy Analyst Austin.flack@mail.house.gov

Re: Written responses to submitted Questions for the Record (QFRs) related to the Oversight Subcommittee hearing entitled "Putting Kids First: Addressing COVID-19's Impacts on Children."

Congressman Peters,

Thank you for the thoughtful questions you submitted for the record and extending me the opportunity to respond. Please know I am at your or your staff's disposal should you have any additional follow up.

Margare Resolver Margaret G. Rush, MD, MMHC

President, Monroe Carell Jr. Children's Hospital at Vanderbilt Professor of Clinical Pediatrics, Vanderbilt University Medical Center

1. Discuss Centers for Medicare and Medicaid Services (CMS) definition of Qualified Residential Treatment Programs (QRTPs) as not being Institutions of Mental Disorders (IMDs).

I agree that it is important to provide access for temporary stays in residential treatment facilities for children in foster care with serious emotional and behavioral health disorders. Appropriate reimbursement structures directly affect the placement opportunities at such facilities. Children and adolescents who do not require the acute inpatient care of a children's hospital or inpatient psychiatric hospital may present mental and behavioral health challenges difficult to treat solely in outpatient community settings. QRTPs, by design, provide traumainformed mental health and substance use disorder treatment on a time-limited basis in a supervised residential setting.

As you know, the Family First Prevention Services Act (FFPSA) sought to reform many aspects of the child welfare system and established a new designation of qualified residential treatment programs (QRTPs). CMS guidance related to the FFPSA stipulate that QRTPs with more than 16



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beds are in most cases subject to the IMD exclusion for Medicaid funding purposes. Since this guidance was issued, I am aware that states have explored varied approaches to implementation of the FFPSA and designation of QRTPs. Given implementation strategies by sates are still playing out, I would urge Congress and the Medicaid and CHIP Payment and Access Commission (MACPAC) to monitor in the months to come whether an effective bed-limitation of QRTPs present a barrier to access. Congress might also take this opportunity to engage in a broader discussion on the IMD exclusion. Efforts to modernize the IMD policy and Medicaid's role in supporting inpatient behavioral health services has recent precedent, with the SUPPORT Act of 2018 allowing for limited exemption from the IMD exclusion for some institutes of Mental Diseases caring for individuals with substance use disorders.

2a. What can Children's Hospitals do to work to address the rise in eating disorders cases given the strain on treatment capacity?

Eating disorders (EDs) are a serious mental health illness that predominantly impact adolescents and young adults (AYAs). Additionally, those with an ED diagnosis often have comorbid mental health issues such as depression, anxiety, and obsessive-compulsive disorders. If not treated appropriately, EDs contribute to physical health issues that negatively impact quality of life and long-term health. A recent study¹ has shown an increase in the number of ED-related hospitalizations, bed days, and patient/parent ambulatory requests for care above prepandemic baseline. As I and others mentioned in our testimonies on September 22, 2021, the infrastructure to support the mental health of children, adolescents, and adults, including those with EDs, is woefully under-resourced in this country.

Similar to other mental health diagnoses, children's hospitals are the safety-net of rescue after the systems of care have failed to prevent or treat those with EDs. Adolescents and young adults with EDs are admitted to inpatient acute care units when their ED has resulted in serious medical and life-threatening complications such as electrolyte and cardiovascular disturbances. Children's hospitals are the landing spot for crisis management.

Like other mental health diagnoses, there is now a greater demand than supply of accessible treatment resources and programs for EDs. There are not enough inpatient facilities to launch recovery from an ED crisis. There are not enough partial hospitalization or intensive outpatient therapy (IOP) programs for EDs. While children's hospitals could invest in the establishment of eating disorder units, this is not ideal use of space for creation of a true therapeutic environment for this chronic mental health diagnosis. With this said, children's hospitals can and should consider opportunities for building a tiered system of care that includes sufficient resources to support AYAs with EDs admitted for crisis management but more importantly focuses on ambulatory partial hospitalization and IOPs. This will require collaboration with behavioral health and nutrition experts. These are the building blocks to help contain ED symptoms and enable appropriate attention to other behavioral health comorbidities.

2b. What additional resources are needed to adequately treat eating disorders in children and adolescents?

The building of a tiered program for EDs, and frankly all mental health disorders, requires enhanced infrastructure that starts with parity in reimbursement for mental health diagnoses compared with physical diagnoses. If children's hospitals, as the safety net for crisis

management, are expected to do this, we must have both federal and state funding commitments to invest in the resources needed to build tiered systems of care, inclusive of training for a variety of healthcare providers. We must also be supported to evaluate new models of care for treatment and prevention, such as how to optimally use telehealth for increased accessibility to services.

My colleagues at the Children's Hospital Association and I continue to support the concrete steps Congress should take to help children and adolescents with EDs as well as other mental health disorders. To quote Dr. Deborah Katzman<sup>2</sup>, "it is time" to rally together and do better to support young people.

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#### November 5, 2021

Response to Additional Questions for the Record Subcommittee on Oversight and Investigations Hearing on "Putting Kids First: Addressing COVID-19's Impacts on Children" September 22, 2021

Arthur C. Evans, Jr., PhD, Chief Executive Officer, American Psychological Association

#### Questions: The Honorable Scott H. Peters (D-CA)

1. It is clear that the covid pandemic has been harmful to the mental health of children for a variety of reasons, but even more so for foster children, who often have higher need for mental health services. As a result of the pandemic, mental health appointments, placement appointments, and other in-person activities were suspended or delayed, disrupting the routines of these vulnerable children. Across the country, including in my district in San Diego County, qualified residential treatment program (QRTP) facilities currently provide placement, educational, and supportive services, including mental health treatment, to youth experiencing foster care. QRTPs with more than 16 beds will soon be deemed to be "institutions of mental disorders" (IMDs) by the Centers for Medicare and Medicaid Services. This means congregate foster care facilities will be unable to receive Medicaid funding to care for these children. Can you talk about whether you agree with CMS that QRTPs are not IMDs in practice?

The question of sufficient and sustainable funding for congregate foster care facilities is an important one. In short, it matters less where the funding comes from, and more what regulations and restrictions are in place around how the money is spent. Depending on the source, funding sometimes comes with strings attached that are overly rigid or, equally as problematic, lacking any guidance. Proper funding regulations need to be in place to ensure money is spent on the highest quality services that are both culturally appropriate and informed by the best science to get the best possible outcomes for children. If these congregate foster care facilities are no longer being funded by CMS, we need to make sure that there is adequate and immediate funding to continue supporting the services these facilities provide. The current lack of standardized expectations for residential care programs is problematic. Moreover, we know that approaches outside of residential care – like involving the child's family (e.g., through multisystemic family therapy – are important in explaining children's variable outcomes.

There is robust behavioral science and psychological research that speak to the connection between characteristics and quality of residential care and children's variable outcomes, as well as children's differential susceptibility to environmental factors and social determinants of health. The existing literature on residential care makes clear that certain factors foster a more therapeutic environment and thus, are associated with better outcomes for children in these settings. One is the inclusion of behavioral approaches to care. For instance, using a "token economy" system to reinforce desired behaviors and dissuade undesired behaviors has been effective among pre-delinquent youth in residential care and children in foster care settings.

Another factor is the inclusion of evidence-based behavioral health approaches to care, which stresses the importance of infusing approaches into residential foster care settings that consider the 'whole child' (i.e., both individual and environmental effects on health and wellbeing). The literature suggests that numerous factors impact the effectiveness of implementing these types of behavioral health approaches, such as the ratio of staff to children, availability of wraparound care, and adequate funding. A third important factor is the inclusion of non-behavioral components of care. Currently, many residential foster care settings are grossly understaffed and rely primarily on medication management. These settings are in dire need of funding to support the training of staff and the use of evidence-based approaches, such as Trauma-focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT uses the science on trauma to ensure posttraumatic growth and improve emotion regulation in children, and has been shown to be effective among diverse youth, including those in foster care and those who have experienced parental abuse or neglect.

Additionally, we must consider the broader environmental factors affecting children's behavioral health and how these are addressed in residential care settings or using other approaches. Many of these factors – such as a lack of adequate services in the community and social stigma – existed long before the pandemic's arrival. Psychological research consistently demonstrates that the behavioral health of children is closely tied to the health of their surroundings, including their homes, schools, and neighborhoods, such that if traumatic events occur in these settings, they frequently have a downstream impact on children's wellbeing. The stakes of untreated behavioral health challenges are especially great for children and adolescents, with the potential for adverse outcomes to compound over time and negatively impact the overall trajectory of their development. This includes a greater likelihood of learning difficulties, substance use, unemployment, and involvement with the criminal justice system later in life.

Many children living in foster care come from unstable families, have been abused, neglected, or experienced other trauma, and as a result, are more likely to have mental health problems. Yet the pandemic lessened detection of child abuse or mistreatment. Traditionally, schools—where teachers and other school-based professionals, including mental health providers, are trained to spot warning signs—have served as safe spaces for children living in abusive homes. COVID-19 took away several systemic safety nets for millions of Americans and with child abuse reports, investigations, substantiated allegations, and interventions declining. Moreover, there has been increased exposure to trauma among kids living in unsafe home environments over the past 18 months

Building a comprehensive system for early screening and intervention, as well as addressing social determinants of health, requires a coordinated response from multiple governmental entities, agencies, and departments. APA has recommended stronger collaboration and partnerships—including coordination of ongoing data collection efforts on the impact of COVID-19 on the behavioral health of children—between the Department of Education, the Department of Health and Human Services, and the Substance Abuse and Mental Health Services Administration.

2. Dr. Evans, I'm curious about the impact on distance learning and the increased social isolation seen in the pandemic has had on mental health in children and adolescents. It seems that some of the stressors typically seen in school aged children, like bullying and social comparison, may be lessened in distance learning. However, numerous new stressors have obviously taken hold, such as fear of the virus, illness,

grief, and lack of social interactions which may harm development. Could you speak as to trends you're seeing in mental illness among children and adolescents in the times of covid?

Although we have still not seen the full extent of the pandemic's impact on children, current data suggest increased levels of behavioral health challenges, such as anxiety, depression, and suicidal ideation among children with and without a pre-existing behavioral health diagnosis. Social isolation, financial uncertainty, and disrupted routines have placed considerable stress on children and their families, which both directly and indirectly affect children's mental health and wellbeing. Many children have experienced significant traumatic events, such as the loss of a parent, caregiver or loved one and exposure to maltreatment or abuse, that can undermine their sense of safety and stability. Data also illustrate that these impacts disproportionately affect traditionally vulnerable populations, including children of color, LGBTQ+ youth, and those with physical or developmental disabilities.

In March 2020, schools had little choice but to pivot to a virtual learning environment. This was a critical move to ensure that children were physically safe, given how much we did not know about the transmissibility of the virus. Despite some of the demonstrated shortcomings of distance learning in meeting children's diverse needs (e.g., less peer interaction, lack of necessary equipment and/or internet access for those in low-income and rural communities, differential levels of caregiver support and availability, etc.), this approach was essential to protect children's physical health in the midst of a pandemic.

Since then, we have learned and adopted necessary safety and mitigation protocols, making safe in-person learning possible and reducing the acute pressure of the distance learning shortcomings noted above. However, this experience with distance learning should open our nation's eyes to the fact that some characteristics of distance learning were indeed beneficial to children, particularly those with existing social anxieties or who struggled to concentrate in overloaded classrooms. In short, children can thrive in both in-person and virtual/distance learning environments, and there are positive and negative implications of both approaches. Our primary job is to ensure that we are addressing the concerning broader trends in children's behavioral health and determining the school- and distance learning-related factors contributing to these adverse outcomes (e.g., bullying, overuse of social media, more loneliness, etc.).

As I mentioned in my written testimony, this requires utilizing a population health approach, which recognizes children's behavioral health along a continuum of need and the need for a broader set of strategies – informed by public health and psychological science – to intervene appropriately along that continuum (i.e., providing effective and efficient clinical care for those with a diagnosed behavioral health condition; mitigating risk or intervening as early as possible for those at-risk for behavioral health challenges; and keeping well those children who are relatively healthy). While a more 'traditional approach' involves waiting for children to reach a point of crisis and then intervening in their learning environments to address their behavioral health needs, a population health perspective extends beyond this reactive approach to shape children's learning environments themselves. This means bringing forth the best scientific thinking to make a child's learning environment and school climate as safe and effective as possible.

In many communities, schools are an essential—and often the only—source of meeting the physical and mental health needs of students and families. They must be provided the resources to (1) increase the school-based mental health workforce, including school psychologists; (2) foster

necessary community partnerships; and (3) provide training to educators on culturally competent social and emotional learning and trauma-informed teaching practices. Fostering positive school climates and developing skills among students such as motivation and engagement, problemsolving, emotional intelligence, resilience, agency, and relationship building will be critical.

To allow schools to build necessary long-term capacity in these areas, federal investments must be both equitable and sustainable. Two bills mentioned in my written testimony would help accomplish this goal: the Comprehensive Mental Health in Schools Pilot Program Act (H.R. 3549) and the Increasing Access to Mental Health in Schools Act (H.R. 3572). Additionally, the Mental Health Professionals Workforce Shortage Loan Repayment Act (H.R. 3150)—which authorizes a new student loan repayment program for behavioral health care professionals who commit to working in an area lacking accessible care—would help address mental health workforce shortages, including in schools. Finally, the committee should build on the distance learning investments made through the American Rescue Plan's Emergency Connectivity Fund by passing the Securing Universal Communications Connectivity to Ensure Students Succeed (SUCCESS) Act (H.R. 4663), which provides funding for devices and broadband connectivity to the 12 to 17 million students who do not have home internet access following the COVID-19 pandemic.

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