Preliminary Transcript

RPTR MOLNAR

EDTR ZAMORA

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, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m., in Room 2123, Rayburn House Office Building, Hon. Diana DeGette [chairman of the subcommittee] presiding.

Present: Representatives DeGette, Kuster, Rice, Schakowsky, Tonko, Ruiz, Peters, Schrier, Trahan, O'Halleran, Pallone (ex officio), Griffith, 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, Press 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; 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 Investigations 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 microphone.

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 loud speakers 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 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.

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 other 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 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 seat belts 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 capacity 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.

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

[The prepared statement of Ms. DeGette follows:]

******** COMMITTEE INSERT ********

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 school-aged 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 efficacy 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:]

******** COMMITTEE INSERT ********

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.

The Chairman. 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 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, 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 Chairman Pallone follows:]

******** COMMITTEE INSERT ********

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.

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 fearmongering 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 students 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 Director, 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 status.

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:]

******** COMMITTEE INSERT ********

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.

[The information follows:]

******** COMMITTEE INSERT ********

Ms. DeGette. 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 testifying 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.

TESTIMONY OF LEE SAVIO BEERS, M.D., F.A.A.P., PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS (AAP); MARGARET G. RUSH, M.D., PRESIDENT, MONROE CARELL JR. CHILDREN'S HOSPITAL AT VANDERBILT; ARTHUR 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

TESTIMONY OF LEE SAVIO 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 pediatricians 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 check-ups.

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:]

******** COMMITTEE INSERT ********

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.

TESTIMONY 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 becoming 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 infections. 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:]

******** COMMITTEE INSERT ********

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

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

TESTIMONY OF ARTHUR 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:]

******** COMMITTEE INSERT ********

Ms. DeGette. Thank you so much, Dr. Evans.

I'm now very pleased to recognize Ms. Danielpour for 5 minutes.

TESTIMONY 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 University.

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 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. 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.

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 [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:]

******** COMMITTEE INSERT ********

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.

TESTIMONY OF TRACY BETH HOEG, M.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 epidemiology-related Ph.D. and postdoctoral work. And I'm a mom of 10- and 13-year-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 kinds.

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 seven 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:]

******** COMMITTEE INSERT ********

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, 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. -- 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 backwards 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 mike on. Thanks.

Dr. Evans. Yeah, 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 [inaudible] and the vaccine [inaudible] 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. Yeah, 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. Yeah, 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. Yeah, 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.

RPTR GIORDANO

EDTR HUMKE

[11:30 a.m.]

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. Yeah. 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. Yeah. 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 fallen 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.

The Chairman. 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 mike 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.

The Chairman. 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 access 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.

The Chairman. 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.

The Chairman. 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 them.

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.

The Chairman. Thank you.

Thank you, Madam Chair.

Ms. DeGette. I thank the gentleman.

The chair now recognizes the full committee ranking member, Mrs. Rogers, 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-19 -- what risk COVID-19 poses to children, and how does that risk compare across age groups and compare to adults?

Dr. Hoeg. Yeah. 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 five to six deaths per million among children.

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. Yeah.

Mrs. Rodgers. Other mental health, social, emotional development impact 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. Yeah. 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 seven 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 mental 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 two 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 five.

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. Yeah. Thank you.

Dr. Hoeg. -- 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 yield back.

Ms. DeGette. I thank the gentlelady.

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 as well.

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 everyone, 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 children.

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 is 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 -- yeah, we have jurisdiction over public health. We also have jurisdiction over tech and tech issues. So it seems -- and even Ms. 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? Okay.

Mr. Burgess. Yes, Dr. Evans --

Dr. Evans. Sure.

Mr. Burgess. -- 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, okay? 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 cyberbullying, 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. Yeah, 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 for 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. -- 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 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 adjustments 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 Ms. 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 having 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 are.

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 well-being, 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 impact.

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 stretching 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, re-instilling 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. Yeah. 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 reinforcing 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. Yeah. 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 misinformation?

Dr. Beers. Yeah. Yeah. 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 -- 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 -- what saddens me the most is that it -- 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 a 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 gentlelady.

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

Mr. Palmer. I thank the gentlelady 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 five.

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 homeschooled. And what we've seen through the years, again, political science being applied to homeschooled children to talk about socialization and issues like that, when, in fact, there is no issues with socialization in homeschooled, 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 homeschooled 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 school teacher 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. -- 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 a extraordinarily safe and effective vaccine. You know, 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 thinking 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. -- 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. Okay. 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 school children for T cell immunity could truly guide science-based decisions about masking, social distancing, and vaccination 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. Yeah. 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. Yeah. 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. Yeah. 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. Yeah, yeah.

Mr. Dunn. -- 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, yeah.

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, D.C. 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 happen.

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 parents 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.

RPTR MOLNAR

EDTR ZAMORA

[12:32 p.m.]

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 appreciate 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 school 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. Yeah. 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 pediatrician, 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 hardworking 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 potentially is?

Dr. Beers. Yeah, 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. Yeah, 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. Yeah, 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. Yeah. 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. Yeah. 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 protect 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 gentlelady. 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 to you.

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. Yeah, 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 support safe schools as students return to the classroom?

Dr. Beers. Yeah, 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 [inaudible] 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 puberty, fertility.

And I do believe [inaudible] increase confidence. I think, hopefully, FDA approval will do so. But I do think [inaudible] 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, they told me [inaudible] 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 [inaudible] 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 gentlelady's time is expired.

Mrs. Trahan. Thank you. I yield back.

Ms. DeGette. The gentlelady'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 much needed 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 arised 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 long-term 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. Yeah. 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 I quote, "the benefits of in-person school outweigh the risks in almost 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 reopen 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. Okay. 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. Yeah. 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 guidance was released?

Dr. Beers. Yeah. 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. Okay. 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.

Okay. 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.

Yeah, 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. Okay. 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.

And 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. Yeah.

Mr. Carter. Thank you.

Mr. Peters. Real 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. Okay. Thank you, Dr. Hoeg, Dr. Beers.

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.

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. Yeah. 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 infected, 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 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 September 14, 2021.

Without objection, that is ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Peters. With that, the subcommittee is adjourned.

[Whereupon, at 1:08 p.m., the subcommittee was adjourned.]