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Oversight and Investigations Subcommittee

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

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

Pediatric COVID-19 Cases and the Delta Variant

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

As of September 16, more than 5.5 million children have been infected by the virus since the start of the pandemic, representing more than 15 percent of the total cumulative cases. Over 21,000 children have been hospitalized and 480 children have died as a result of COVID-19.[1] Recent CDC data shows that COVID-19–associated hospitalizations rates are 2.5–3.0 times higher than influenza-associated hospitalizations.[2] Among deaths attributed to COVID-19, more than two-thirds of these have been in Black and Latinx children. In addition, COVID-19 is currently one of the ten leading causes of death for children in the United States.[3]

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

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

Pediatric COVID-19 Vaccine Development and Authorization

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

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

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

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

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

Pediatric COVID-19 Vaccination Rates

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

Most recently, 273,000 children received their first COVID-19 vaccine the week of September 16. Unfortunately, that number of children receiving their first dose represented a decline for a fifth straight week and is at its lowest level since the vaccine was made available to 12–15-year-olds.[7] In fact, the number of weekly first-dose vaccinations remains far below the peak of 1.6 million at the end of May. Adolescent vaccination rates vary substantially across states. For example, in 15 states, over 60 percent of 12-17-year-olds have received at least one dose, and in 11 states, fewer than 40 percent have received one dose. It is so important that we work to address these geographic disparities so that children everywhere can be protected for COVID-19 and its effects. With the return to school, it is particularly imperative that we redouble our efforts to vaccinate all eligible 12- to 17-year-olds.

Vaccine Hesitancy

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

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

While it is imperative to call out misinformation, it is also important to recognize that the reasons for vaccine hesitancy can vary across communities. Some hesitancy is borne out of lived experiences, particularly among African Americans and other groups which have historically experienced inequitable care. The hesitancy in these communities was highlighted by a survey conducted by the African American Research Collaborative and The Commonwealth Fund in June, which showed that more than 40 percent of Black and Latinx American polled in their American COVID-19 Vaccine Poll were unvaccinated and still hesitant to get a COVID-19 vaccine.[8] But there was also encouraging news in the same poll. Among those surveyed, 60 percent said that their personal doctor/primary care physician was the most effective messenger to encourage them to get a shot. Another 53 percent of those surveyed said they preferred to be vaccinated against COVID-19 vaccine in their doctor's office.

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

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

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

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

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

Returning Children Safely to In-Person Schooling

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

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

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

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

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

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

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

Emotional and Behavioral Health Needs of Children

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pediatric Mental Health Workforce Needs

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

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

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

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

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

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