LESSONS LEARNED: CHARTING THE PATH TO EDUCATIONAL EQUITY

HEARING

BEFORE THE

SUBCOMMITTEE ON EARLY CHILDHOOD, ELEMENTARY, AND SECONDARY EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR U.S. HOUSE OF REPRESENTATIVES

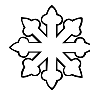
ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, MARCH 25, 2021

Serial No. 117–5

Printed for the use of the Committee on Education and Labor



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43–873 PDF WASHINGTON : 2022

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LESSONS LEARNED: CHARTING THE PATH TO EDUCATIONAL EQUITY

Thursday, March 25, 2021

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON EARLY CHILDHOOD,
ELEMENTARY, AND SECONDARY EDUCATION,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:01 p.m., via Zoom, Hon. Gregorio Kilili Camacho Sablan (Chairman of the subcommittee) presiding.

Present: Representatives Sablan, Hayes, Grijalva, Yarmuth, Wilson, DeSaulnier, Morelle, McBath, Levin, Manning, Bowman, Scott (Ex Officio), Owens, Grothman, Allen, Keller, Miller, Cawthorn, Steel and Foxx (Ex Officio).

Staff present: Phoebe Ball, Disability Counsel; Ilana Brunner, General Counsel; David Dailey, Counsel to the Chairman; Sheila Havenner, Director of Information Technology; Eli Hovland, Policy Associate; Ariel Jones, Policy Associate; Andre Lindsay, Policy Associate; Max Moore, Staff Assistant; Mariah Mowbray, Clerk/Special Assistant to the Staff Director; Kayla Pennebacker, Staff Assistant; Veronique Pluviose, Staff Director; Benjamin Sinoff, Director of Education Oversight; Lakeisha Steel, Senior Education Policy Advisor; Claire Viall, Professional Staff; Cyrus Artz, Minority Staff Director; Kelsey Avino, Minority Professional Staff Member; Courtney Butcher, Minority Director of Member Services and Coalitions; Amy Raaf Jones, Minority Director of Education and Human Resources Policy; Dean Johnson, Minority Legislative Assistant; Hannah Matesic, Minority Director of Operations; Audra McGeorge, Minority Communications Director; Carlton Norwood, Minority Press Secretary; Chance Russell, Minority Legislative Assistant; Mandy Schaumberg, Minority Chief Counsel and Deputy Director of Education Policy; and Brad Thomas, Minority Senior Education Policy Advisor.

Chairman SABLAN. The Subcommittee of Early Childhood Elementary and Secondary Education will come to order. Welcome everyone. I note that a quorum is present. The subcommittee is meeting today to hear testimony on Charting the Path to Education Equity Post-COVID–19. And this is an entirely remote hearing.

All microphones will be kept muted as a general rule to avoid unnecessary background noise. Members and witnesses will be responsible for unmuting themselves when they are recognized to speak, or when they wish to seek recognition. I also ask the Members please identify themselves before they speak.

Members should keep their cameras on while in the proceeding. Members shall be considered present in the proceeding when they are visible on camera, and they shall be considered not present when they are not visible on camera. The only exception to this is if they are experiencing technical difficulty and inform committee staff of such difficulty.

If any Member experiences technical difficulties during the hearing you should stay connected on the platform, make sure you are muted and use your phone to immediately call the committee's IT director whose number was provided in advance.

Should the Chair experience technical difficulty or need to step away, Chairman Scott as a Member of this subcommittee, or another Majority Member of the subcommittee if Chairman Scott is not available, is hereby authorized to assume the gavel in the Chair's absence.

This is an entirely remote meeting. And as such the Committee's hearing room is officially closed. Members who choose to sit with their individual devices in the hearing room must wear headphones to avoid feedback, echoes and distortion resulting from more than one person on the software platform sitting in the same room.

Members are also expected to adhere to social distancing, and safe healthcare guidelines including the use of masks, hand sanitizers and wiping down their areas, both before and after their presence in the hearing room. In order to ensure that the Committee's five-minute rule is adhered to, staff will be keeping track of time using the Committee's field timer.

The field timer will appear in its own thumbnail picture and will be named 001_timer. There will be no one minute remaining warning. The field timer will sound its audio alarm when time is up, and it goes really loud—"bzzzzzz." Members and witnesses are asked to wrap up promptly when their time has expired.

While a roll call is not necessary to establish a quorum in official proceedings conducted remotely or with remote participation, the committee has made it a practice whenever there is an official proceeding with remote participation for the Clerk to call the roll to help make clear who is present at the start of the proceeding.

Members should say their name before announcing they are present. This helps the clerk, and also helps those watching the platform and the livestream who may experience a few seconds delay.

So, at this time I ask the Clerk to call the roll.

The CLERK. Chairman Sablan?

Chairman SABLAN. Sablan is present.

The CLERK. Mrs. Hayes.

Mrs. HAYES. Hayes is present.

The CLERK. Mr. Grijalva?

Mr. GRIJALVA. Present.

The CLERK. Mr. Yarmuth?

Mr. YARMUTH. Present.

The CLERK. Ms. Wilson?

Ms. WILSON. Miss Wilson is present.

The CLERK. Mr. DeSaulnier?

[No response.]

The CLERK. Mr. Morelle?

Mr. MORELLE. Mr. Morelle is present.
The CLERK. Mrs. McBath?
Mrs. MCBATH. Mrs. McBath is present.
The CLERK. Mr. Levin?
Mr. LEVIN. Levin is present.
The CLERK. Ms. Manning?
Ms. MANNING. Manning is present.
The CLERK. Mr. Bowman?
[No response.]
The CLERK. Mr. Scott?
Mr. SCOTT. Scott is present.
The CLERK. Ranking Member Owens.
Mr. OWENS. Owens is present.
The CLERK. Mr. Grothman?
[No response.]
The CLERK. Mr. Allen?
[No response.]
The CLERK. Mr. Keller?
Mr. KELLER. Keller is present.
The CLERK. Mrs. Miller?
Mrs. MILLER. Miller is present.
The CLERK. Mr. Cawthorn?
[No response.]
The CLERK. Mrs. Steel?
Mrs. STEEL. Steel present.
The CLERK. Mrs. Foxx?
Mrs. FOXX. Foxx is present.
The CLERK. Chairman Sablan this concludes the roll call.

Chairman SABLAN. Thank you. Thank you very much. And pursuant to Committee Rule 8(c), opening statements are limited to the Chair and the Ranking Member, and this allows us to hear from our witnesses sooner, and provides all Members with adequate time to ask questions.

I recognize myself now for the purpose of making an opening statement.

Today we meet for charting the impact of the COVID–19 pandemic on school communities and discuss strategies for safely reopening classrooms and addressing educational disparities. It has been just over a year since the pandemic forced schools to abruptly switch to online platforms, disrupting the education of more than 55 million students, and upending our communities.

Unfortunately, the consequences of this transition have extended beyond lost in person instructions. School closures have restricted student's access to nutritious school meals, and social and emotional learning opportunities.

And schools are less likely to identify cases of child abuse and neglect while classrooms are closed. In my district COVID–19 has had the greatest impact on students with disabilities, Title I qualified students, English learners and other vulnerable students that already face significant challenges.

Going into the pandemic, schools that are predominantly just serving students of color faced a 23-billion-dollar funding gap compared to schools predominantly serving white students. And because of this disparity many students entered the pandemic with-

out access to high-speed internet, dedicated devices, and other things that are critical to remote learning.

They will also return to older classrooms and campuses with much needed repairs, from iPhones, some even to find school libraries losing their entire book collection, books meant for student literacy. Dilapidated school facilities, including dangerously outdated ventilation systems if they are there at all.

The perfect storm of disparities has worsened inequities in unfinished learning and often measurable widening of achievement gaps. Research indicates black and Latino students were three to 5 months behind in learning at the beginning of this school year. By the end of the school year, they could be 6 to 12 months behind, compared to 4 to 8 months for white students.

GAO reporting found that school districts struggled to provide education and services for students with disabilities and English learners. Further, a new survey by the National Assessment of Education Progress, or NAEP, found that more than half of all black, Latino and Asian fourth graders learned in a fully remote environment.

Another survey showed that only about a quarter of Pacific Islanders received full-time, in-person instruction. In comparison, 25 percent of white students learned fully remotely, and nearly half of white students received full-time in-person instructions.

Students with disabilities have also disproportionally suffered from this pandemic in the wake of the Trump administration's failed COVID–19 response. Without adequate guidance from the Department, schools struggled to maintain the special education services that students with disabilities needed to access quality education in a remote learning environment.

Today, schools also face challenges to reopening classrooms for students with disabilities, who may be more vulnerable to the virus. For example, the NAEP 2021 survey showed that 40 percent of schools prioritized students with disabilities for full-time in-person instruction in the 4th and 8th grades.

Yet, students with disabilities have not received in-person instructions at rates noticeably higher than other subgroups of students. These continued disparities make clear that to ensure that all schools and students recover from this pandemic, we must target relief and resources to underserved students who need them most.

Over the past year, Congress has taken historic steps toward that goal through three major relief packages: The Coronavirus Aid, Relief, and Economic Security Act, or the CARES Act, the Coronavirus Response and Relief Supplemental Appropriations Act, and the most recently American Rescue Plan Act.

Combined together, these packages secured nearly 200 billion dollars in urgent relief for schools. The funding has been critical for covering the increased costs of the pandemic and preparing for the 300 billion dollars shortfall in State and local budgets. To date, a reduced State revenue has already cost more than a million education jobs.

The American Rescue Plan specifically makes the most significant one-time investment in K through 12 education in our Nation's history. Under President Biden, Congress swiftly passed this

legislation after school communities spent months calling for additional funding to reopen schools safely and support students.

The nearly 130 billion dollars of flexible funding in this package will help schools take the necessary steps to safely reopen and stay open. And it will help students overcome lost time in the classrooms as well as severe trauma, hunger, and homelessness.

The American Rescue Plan funding will also help Congress to fulfill its long-standing commitment to meeting the needs of students with disabilities. Specifically, the package dedicates 3 billion dollars to ensure that K through 12 students with disabilities can access the free and appropriate public education they have a right to, and toddlers with disabilities can access the services they need to be ready to enter the school system.

The lessons from our pandemic response so far have provided a valuable foundation for Congress to take the next steps toward educational equity. For example, we need accurate data from statewide assessments to understand the full scope of this pandemic.

Without this data, we cannot accurately target relief funding to support school communities where racial achievement gaps are greatest. We must also make systemic reforms to our K through 12 education system to fully address educational disparities. And this includes repairing crumbling school infrastructure, confronting the growing resegregation of public schools, and making other long-term investments to address educational disparities.

Today, we will discuss the work we still have ahead to close persistent achievement gaps and ensure a recovery from this pandemic where every student succeeds. I want to thank our witnesses again for being with us and I now go to the Ranking Member of the Full Committee Ranking Member Dr. Foxx for her opening statement.

[The statement of Chairman Sablan follows:]

STATEMENT OF HON. GREGORIO KILILI CAMACHO SABLAN, CHAIRMAN, SUBCOMMITTEE ON EARLY CHILDHOOD, ELEMENTARY, AND SECONDARY EDUCATION

Today, we meet to examine the impact of the COVID–19 pandemic on school communities and discuss strategies for safely reopening classrooms and addressing educational disparities.

It has been just over a year since the pandemic forced schools to abruptly switch to online platforms, disrupting the education of more than 55 million students and upending our communities.

Unfortunately, the consequences of this transition have extended beyond lost in-person instruction. School closures have restricted students' access to nutritious school meals and social and emotional learning opportunities. And schools are less likely to identify cases of child abuse and neglect while classrooms are closed.

In my district, COVID–19 has had the greatest impact on students with disabilities, Title I qualified students, English learners, and other vulnerable students that already faced significant challenges.

Going into the pandemic, schools predominantly serving students of color faced a $23 billion funding gap compared to schools predominantly serving white students.

Because of this disparity, many students entered the pandemic without access to high-speed internet, dedicated devices, and other tools that are critical to remote learning. They will also return to older classrooms and campuses with much-needed repairs, from iPhones-some even to find school libraries losing their entire book collection-books meant for student literacy-and dilapidated school facilities, including dangerously outdated ventilation systems, if they are there at all.

The perfect storm of disparities has worsened inequities in unfinished learning and caused a measurable widening of achievement gaps.

Research indicates Black and Latino students were 3–5 months behind in learning at the beginning of this school year. By the end of the school year, they could be 6–12 months behind, compared to 4–8 months for white students.

GAO reporting found that school districts struggled to provide education and services for students with disabilities and English learners. Further, a new survey by the National Assessment of Educational Progress, or NAEP, found that more than half of all Black, Latino, and Asian fourth graders learned in a fully remote environment. Another survey showed that only a quarter of Pacific Islanders received full-time, in-person instruction. In comparison, 25 percent of white students learned fully remotely, and nearly half of white students received full-time in-person instruction.

Students with disabilities have also disproportionally suffered from this pandemic in the wake of the Trump Administration's failed COVID–19 response. Without adequate guidance from the Department, schools struggled to maintain the special education services that students with disabilities needed to access quality education in a remote learning environment. Today, schools also face challenges to reopening classrooms for students with disabilities, who may be more vulnerable to the virus. For example, the NAEP 2021 Survey shows that 40 percent of schools prioritized students with disabilities for full-time in-person instruction in the 4th and 8th grades. Yet, students with disabilities have not received in-person instruction at rates noticeably higher than other subgroups of students.

These continued disparities make clear that, to ensure that all schools and students recover from this pandemic, we must target relief and resources to underserved students who need them most.

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- the Coronavirus Response and Relief Supplemental Appropriations Act, and most recently,
- the American Rescue Plan Act.

Combined, these packages secured nearly $200 billion in urgent relief for schools. The funding has been critical for covering the increased costs of the pandemic and preparing for the $300 billion shortfall in State and local budgets. To date, reduced State revenue has already cost more than a million education jobs.

The American Rescue Plan, specifically, makes the most significant one-time investment in K–12 education in our Nation's history. Under President Biden, Congress swiftly passed this legislation after school communities spent months calling for additional funding to reopen schools safely and support students.

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The lessons from our pandemic response so far have provided a valuable foundation for Congress to take the next steps toward educational equity.

For example, we need accurate data from statewide assessments to understand the full scope of this pandemic. Without this data, we cannot accurately target relief funding to support school communities where racial achievement gaps are greatest.

We must also make systemic reforms to our K–12 education system to fully address educational disparities. This includes repairing crumbling school infrastructure, confronting the growing resegregation of public schools, and making other long-term investments to address educational disparities.

Today, we will discuss the work we still have ahead to close persistent achievement gaps and ensure a recovery from this pandemic where every student succeeds.

Mr. OWENS. Mr. Chairman I will take that, Ranking Member. Thank you, Mr. Chairman, and thanks to all our witnesses for joining us.

Chairman SABLAN. Could the gentlemen suspend for a minute?

Mr. OWENS. Yes.

Chairman SABLAN. Dr. Foxx will make her opening statement. She's just trying to unmute herself. Dr. Foxx there should be—the microphone should be on your lower right-hand if you're using a computer. Yes left-hand corner facing you Dr. Foxx.

Ms. FOXX. Banyan can you hear me?

Mr. SCOTT. Yes, yes.

Ms. FOXX. I have no sound.

Chairman SABLAN. Dr. Foxx I apologize. Mr. Owens is actually going to make his opening statements and then on the questioning you're going to be ahead of Mr. Owens, so I apologize, my mistake, so we'll go back and recognize Mr. Owens please.

Mr. OWENS. Thank you.

Chairman SABLAN. Thank you Dr. Foxx, thank you.

Ms. FOXX. Thank you.

Chairman SABLAN. Mr. Owens you have five minutes sir.

Mr. OWENS. Thank you, Mr. Chairman, and thanks for our witnesses for joining us. And shouldn't all children have opportunities to achieve the American dream? It must never be a partisan issue. All students, regardless of zip code or socio-economic status should have the freedom to attend the school that meets their unique needs setting them up for lifelong success.

I grew up in the deep south in a touch with Jim Crow and the KKK. Racial segregation and inequities in education are not just chapters in a history book for me. I lived and experienced them first-hand. I'm the child of educators. My father received his Ph.D. from Ohio State University and taught Agronomy at Florida A and M.

My mother was a junior high school teacher. I was taught from a young age of the importance of education and hard work. I firmly believe education is the key to unlocking our children's future across abilities. Tragically, the COVID–19 pandemic has served as a major setback for K through 12 students nationwide.

The purpose of today's hearing might be to discuss educational equity post COVID–19, but there can be no educational equity when classroom doors remain shut. Too many poor families, many of them students of color, as well as those with disabilities, have been left with no educational options other than to wait on the bureaucrats to—[inaudible]—vote upon the science and reopen schools.

The current administration and this Congress have failed these families. Every day our inaction worsens the education disparities in our communities, which over time will contribute to widening opportunities and wealth gaps. The best way to help struggling families is to give them more freedom to make choices for their children's education, not by shutting them out of schools and closing doors of great opportunities.

While numerous states and schools have listened to the science and implemented proper safety precautions to offer students and families safe, in-person instructions, too many students are trapped in school districts that refuse to reopen, causing irreversible harm to our Nation's children.

This is far from equity, and we must do better. That's why House Republicans called for a bipartisan investigation into the effects

that school closures are having on children with disabilities. In a letter to Chairmen Clayton, Maloney, Scott and Pallone, my fellow Republicans wrote, and I quote, "Students with disabilities are falling behind. States and localities are not meeting even the minimum requirements.

If States and localities are violating Federal civil right laws to the detriment of students, they must be investigated, and their actions corrected." Closed classrooms have also increased mental health problems among the students. CDC data shows that mental health visits to the emergency room increased by 24 and 31 percent with children from March to October of last year.

Additionally, 2020 analysis by McKenzie and Company estimates that children of color may lose up to 1 year of learning compared to white students losing 4 to 8 months, with an average overall learning loss of 9 months.

These numbers are jaw-dropping. We cannot allow future generations to fall further behind while the Biden Administration tiptoes around the radical demands of teacher unions. Embarrassingly, the United Teachers of Los Angeles, UTLA, demanded a host of left-wing priorities such as Medicare for all, defunding the police, wealth, and millionaire taxes, at least 50 billion in school nationwide, housing security and security to school moratorium and a safety requisites in our in-person return to schools.

But rather than address these outrageous wish lists, which have nothing to do with reopening schools, the Democrats have claimed that we all want schools to reopen. Their actions, or lack thereof, speaks louder than words. In addition, the Biden Administration seems to change their tune daily on reopening schools.

Even the Washington Post labeled their messaging as a muddled mess. Let's follow the science. Last week the CDC reversed its course on six feet of social distancing, admitting that their previous guideline was politically motivated. This comes after CDC Director Walensky's statement that schools could reopen before all teachers are vaccinated, a statement that was later reversed because of the pressures from teachers? unions.

Like the CDC, congressional Democrats are willing to bend the facts on their crusade to politicize our children's education. Democrats ran through their so-called CDC relief bill, even though this body had already allocated significantly more funding than the CDC said was necessary to safely reopen schools.

Even worse, the funds appropriated through this partisan legislation have nothing to do with reopening schools this spring. The data is clear. The longer the schools stay closed, the further our children fall behind, particularly those in disadvantaged groups. Yet the Biden Administration and Democrats continue to prioritize unions over students, and politics over science.

This is no way to lead our country through this unprecedented crisis. This is no way to chart a path forward toward educational equality. The science is clear, Congress provided an abundance of funding, yet children are still stuck learning behind a screen, forcing our youngest and most vulnerable to overcome insurmountable barriers to success.

For far too long Congress has bitterly divided on partisan lines. Our kids deserve better. I hope we can come together, not as Re-

publicans and Democrats, but as parents, grandparents, and patriotic Americans to put the well-being of our children first. I look forward to hearing from our witnesses today, particularly Mrs. Jennifer Dale, who will offer testimonies on her testimony, with harmful and lengthy school closures and how it has impacted her family.

Thank you Mr. Chairman and I yield back.

[The statement of Ranking Member Owens follows:]

STATEMENT OF HON. BURGESS OWENS, RANKING MEMBER, SUBCOMMITTEE ON EARLY CHILDHOOD, ELEMENTARY, AND SECONDARY EDUCATION

Ensuring all children have opportunities to achieve the American Dream must never be a partisan issue. All students—regardless of zip code or socioeconomic status—should have the freedom to attend the school that meets their unique needs, setting them up for lifelong success.

I grew up in the deep South during the time of Jim Crow and the KKK. Racial segregation and inequities in education are not just chapters in a history book to me—I've lived and experienced them firsthand. I'm the child of educators—my father received his Ph.D. from The Ohio State University and taught Agronomy at Florida A&M, my mother was a middle school teacher. I was taught from a young age the importance of education and hard work. I firmly believe education is the key to unlocking our children's future of possibilities.

Tragically, the COVID–19 pandemic has served as a major setback for K–12 students nationwide. The purpose of today's hearing might be to discuss educational equity post-COVID–19, but there can be no educational equity when classroom doors remain shut.

Too many poor families, many of them, students of color as well as those with disabilities, have been left with no educational option other than to wait on bureaucrats to follow the science and reopen schools. The Biden administration and this Congress have failed these families. Every day, our inaction worsens the educational disparities in our communities, which over time will also contribute to widening opportunity and wealth gaps. The best way to help struggling families is

to give them more freedom to make choices for their children's education, not by shutting them out of schools and closing doors to greater opportunities.

While numerous states and schools have listened to the science and implemented proper safety precautions to offer students and families safe, in-person instruction, too many students are trapped in school districts that have refused to reopen, causing irreversible harm to our Nation's children.

This is far from equity and we must do better.

That's why House Republicans called for a bipartisan investigation into the effects school closures are having on children with disabilities. In a letter to Chairmen Clyburn, Maloney, Scott, and Pallone, my fellow Republicans wrote, 'Students with disabilities are falling behind. States and localities are not meeting even the minimal requirements? If states or localities are violating Federal civil rights laws to the detriment of students, they must be investigated, and their actions corrected.'

Closed classrooms have also increased mental health problems among students. CDC data shows that mental health visits to the emergency room increased between 24 and 31 percent for children from March to October of last year.

Additionally, a 2020 analysis by McKinsey and Company estimates that children of color may lose up to one year of learning compared to white students losing four to 8 months, with an average overall learning loss of nine months.

These numbers are jaw-dropping.

We cannot allow future generations to fall further behind while the Biden administration tiptoes around the radical demands of teachers unions.

Embarrassingly, the United Teachers of Los Angeles (UTLA) demanded a host of left wing priorities such as Medicare for All, defunding the police, wealth and millionaire taxes, at least $500 billion for schools nationwide, housing security, and a charter school moratorium, as 'safety' prerequisites for their in-person return to school.

But rather than address this outrageous wish list which has nothing to do with reopening schools, Democrats will claim that 'we all want schools to reopen.' Their actions, or lack thereof, speak louder than their words. In addition, the Biden administration seems to change their tune daily on reopening

schools. Even the Washington Post labeled their messaging a 'muddled mess.'

Let's follow the science. Just last week, the CDC reversed its course on six feet of social distancing, admitting that their previous guidance was politically moti-

vated. This comes after CDC Director Walensky's statement that schools could reopen before all teachers are vaccinated, a statement that was later reversed because of pressure from teachers unions.

Like the CDC, congressional Democrats are willing to bend the facts on their crusade to politicize our children's education. Democrats rammed through their so-called COVID relief bill even though this body had already allocated significantly more funding than the CDC said was necessary to safely reopen schools. Even worse, the funds appropriated through that partisan legislation have nothing to do with reopening schools this spring.

The data is clear: the longer schools stay closed the further children will fall behind, particularly those in disadvantaged groups. Yet the Biden administration and Democrats continue to prioritize unions over students and politics over science. This is no way to lead our Nation through an unprecedented crisis. This is no way to chart a path toward educational equity.

The science is clear. Congress provided an abundance of funding. Yet, children are still stuck learning from behind a screen, forcing our youngest and most vulnerable to overcome insurmountable barriers to success. For far too long, Congress has been bitterly divided along partisan lines. Our kids deserve better. I hope we can come together not as Republicans and Democrats, but as parents, grandparents, and patriotic Americans to put the well-being of our children first.

I look forward to hearing from our witnesses today, particularly Mrs. Jennifer Dale, who will offer testimony on her experiences with harmful and lengthy school closures and how it has impacted her family.

Chairman SABLAN. Thank you very much Mr. Owens for your statement. I would just like to say that here on the ground, the CARES Act and the American Rescue Act, there's a lot of teachers to come back to 40-hour work weeks, and schools actually reopened for face to face instructions, and they're now in the process of making plans for summer schools, identifying students who need help and bringing them into summer schools, but thank you for your statement anyway.

Without objection, all other Members who wish to insert written statements into the record may do so by submitting them to the Committee Clerk electronically in Microsoft Word format by 5 p.m. on May 8, 2021.

I will now introduce the witnesses. Marc H. Morial, is President and CEO of the National Urban League, the Nation's largest historic civil rights and urban advocacy organization. He served as the highly successful and popular Mayor of New Orleans, as well as the President of the United States Conference of Mayors.

He previously was a Louisiana State Senator and was an attorney in New Orleans. He's a living voice on the national stage in the battle for jobs, education, policy and voting right equity. He's a graduate of the University of Pennsylvania with a degree in economics and African-American studies and holds a law degree from Georgetown University.

I think the livestream, the Chair has been informed that the livestream is down, and House will require that we suspend until it is back up, so we will pause momentarily. Members and witnesses should maintain the connection to the platform as the hearing will continue as soon as livestream is back up.

[Suspension]

I was introducing the witnesses, and I think I was just saying that Mr. Morial has also got a law degree from Georgetown University.

Ms. Jennifer Dale is a mother of three school-age children and resides in Lake Oswego, Oregon. Oh, my great grandchildren live

there too. In her community Miss Dale is active in volunteering with non-profits that service children of people with disabilities, including serving on the Board of Community which supports independence for people with disabilities in employment and housing.

Last fall Ms. Dale formed a group with other families in the community to push for the return to in-person instructions. Her group, Clack to School named after Clackamas County, has worked with Let Them Play, Let Oregon Learn and opening PDX to become the largest coalition of families advocating to reopen schools which number 35,000 families state-wide.

Selene Almazan, I hope I got that right, is the Legal Director for the Council of Parent Attorneys and Advocates, COPAA. COPAA started as a school membership and training organization for attorneys and advocated for parents to find the help they needed to fight for the rights of their children and now is nationally recognized for harnessing the strength and determination of family attorneys advocates related professional and students.

Ms. Almazan has represented students with families for over 30 years, and in addition to her work with COPAA, maintains a private practice focusing on student representation in special education matters, and matters involving violations of the Individuals With Disabilities Act, the Rehabilitation Act of 1973.

She has extensive experience training families, teachers, school administrators, attorneys and advocates on legal issues related to special education law as well as disability discrimination issues.

I am pleased to recognize my colleague, Representative Frederica Wilson to briefly introduce her constituent who's appearing before us as a witness today. I yield 30 seconds to Ms. Wilson to introduce the witness please. Ms. Wilson, yes Frederica please. I think you need to unmute your microphone. I can't hear you. Can you hear me Frederica, nod if you can?

Ms. WILSON. I hear you.

Chairman SABLAN. OK, oh now I hear you too. Let's go. Introduce your witness please.

Ms. WILSON. Good afternoon. Thank you, Chairman Sablan. I am so proud to introduce my friend, 5000 Role Model Mentor and Miami-Dade County Public School Superintendent Alberto Carvalho. He is the best. And Miami-Dade County Public Schools are open for business and have been for a long time. Children attend according to parental choice.

He has served as Superintendent of Miami-Dade Public Schools, the Nation's fourth largest school system since September 2008, a record of exemplary service. He is a nationally recognized expert on education, transformation, finance, and leadership development.

During his tenure Miami-Dade County Public Schools has become one of the Nation's highest performing urban schools. And because of the 5,000 Role Models, black boys outperform their counterparts in other urban districts. The district has also been named as a 2014 College Board Advance Placement Equity and Excellence District of the Year, as well as the 2012 winner of the Board prize for urban education.

Mr. Carvalho serves on the National Assessment Governing Board. He also serves as a committee Member of the National Academies of Science, Engineering and Medicine, and as an advi-

sory committee Member to the Harvard Program on Education, Policy and Governance. Welcome to the Education and Labor Committee Superintendent Carvalho, all the way from Miami-Dade. We're looking forward to your testimony.

Thank you Mr. Chairman and I yield back.

Chairman SABLAN. Thank you, Ms. Wilson, and to the witnesses again welcome and good afternoon. We appreciate the witnesses that are here participating today and look forward to your testimony. Let me remind the witnesses that we have read your written statements and they will appear in full in the hearing record. Pursuant to Committee Rule 8(d) and committee practice, each of you is asked to please limit your oral presentation to a five-minute summary of the written statement.

I also remind the witnesses that pursuit to Title XVIII of the United States Code, Section 1001, it is illegal to knowingly and willfully falsify any statement, representation, writing, document, or material fact presented to Congress or otherwise conceal or cover up a material fact.

Before you begin your testimony, please remember to unmute your microphone. During your testimony staff will be keeping track of time and a timer will sound with staff when time is up. Please be attentive to the time, wrap up when your time is over and remute your microphone.

If any of you experience technical difficulties during your testimony, or later in the hearing, you should stay connected on the platform, make sure you are muted and use your phone to immediately call the committee's IT director whose number was provided to you in advance.

We will let all the witnesses make their presentations before we move to Member questions. When answering a question please remember to unmute your microphone. And I will first recognize Marc Morial please. Mr. Morial you have five minutes.

STATEMENT OF MARC H. MORIAL, JD, PRESIDENT AND CEO, NATIONAL URBAN LEAGUE

Mr. MORIAL. Thank you very much Mr. Chairman and to Ranking Member Owens, and to each Member of the subcommittee. Thank you, it's always an honor to appear before elected representatives. I also want to acknowledge the leadership of Chairman Scott, with whom we worked for many, many years.

I am President of the National Urban League. I'm also the father of three, and the son of a second-grade teacher. So, the issues that you are considering today are most important to me. The National Urban League serves children in this Nation, in 90 communities, 90 affiliates serving 300 communities, in 36 states.

We provide out of time, or after school services to hundreds of thousands of young people each and every year. At the community level we are advocates. We are advocates of both excellence and equity, and have been actively involved in ensuring the successful implementation of the Every Student Succeeds Act, adopted by the Congress several years ago.

And I appreciate the opportunity to share just for a moment our perspective on the path to educational equity in this COVID–19 environment. Regrettably, black and brown children have faced a dis-

proportionate burden as a result of this pandemic. Black people are more likely to contract, be hospitalized, and die from COVID–19.

Black workers are more likely to be in fields with the most layoffs due to the pandemic. Black children are far more likely than their white counterparts to lack the internet access and the devices necessary to receive adequate, remote instruction, a term we call the homework gap.

Information that we receive from communities across the Nation indicate that as many as 20 to 40 percent of children in many urban school districts have been completely cutoff from learning since the pandemic has begun. Now this is on top of the systemic inequities that we all are aware of and we're trying to solve, and this is not unique to this pandemic.

Jim Crow, the language discrimination and segregation, created a long-standing second-class system of education for children in America. I am a son of the south. The schools I attended were integrated the first years that I attended those schools. Before Brown versus the Board of Education in 1954, it was not uncommon for black fourth grade students to use white, second grade hand me down textbooks.

This history, coupled with the ways by which too many students of color have born the brunt of this pandemic, have resulted in black and Latino students losing an average of 10 months of instruction.

Since the pandemic began and interrupted in-person teaching and learning, compared to an average of 6 months lost for instruction for white students, all of our students have lost instructional time due to this pandemic. Now I want to thank the President and the Members of the House and Senate who voted for the American Rescue Plan, which among many needed supports includes the largest Federal investment in our Nation's history.

And as we look at how COVID–19 has widened opportunity gaps, it is the American Rescue Plan that provides the long overdue support needed for schools to be able to reopen safely, for schools to be able to reintroduce students to in-person instruction, and to do it in a way that is neither haphazard, nor risky, nor knee-jerk.

Now those investments should support development and growth of students grounded in the principles of equity. What do I mean? Mental health supports, devices, and internet connections to close a homework gap, extended learning opportunities, rigorous course work for students of color and low-income students, diverse and qualified teachers and school leaders, restorative practices, social-emotional learning, and positive behavioral support.

These are the types of things with this investment the schools of America should do in order to address the challenges and to the important goal of equity. Now to effectively leverage these resources we need a reliable measure of what our children know.

State-wide assessments provide parents and caregivers with accurate information about how their students are performing on grade level standards. State-wide assessments are not a panacea. They're not a fool-proof method, but they're the best thing we have to know where our children are. I thank you for your focus on this issue and look forward to answering any questions. Thank you so much.

[The prepared statement of Mr. Morial follows:]

PREPARED STATEMENT OF MARC MORIAL

Testimony of Marc H. Morial
President and CEO, National Urban League

Committee on Education and Labor, Subcommittee on Early Childhood Elementary and Secondary Education

Lessons Learned: Charting the Path to Educational Equity Post-COVID-19
March 25, 2021

Chairman Sablan, Ranking Member Owens, and Members of the Subcommittee, thank you for your invitation to participate in this hearing. My name is Marc Morial, and I am the President and CEO of the National Urban League, an organization with a 111-year history of advocating for economic empowerment, equality, and social justice for African Americans and other historically underserved groups. With 90 affiliates serving 300 communities across 36 states and the District of Columbia, the Urban League spearheads the development of social programs and authoritative public policy research, and advocates for policies and services that close the equality gap. At the community level, the National Urban League and its affiliates provide direct services that improve the lives of more than two million people annually.

I appreciate the opportunity to share the perspective of our Urban League Movement on the path to educational equity post-COVID-19. Unfortunately, it is our Black and Brown children who have faced a disproportionate burden both educationally and personally as a result of this pandemic. Black people are more likely to contract, be hospitalized, and die from COVID-19. Black workers are more likely to be in fields with the most layoffs due to the pandemic. Black children are more likely than their White counterparts to lack the internet access and the devices necessary to receive adequate remote instruction, a term we call "the homework gap," which affects 1 in 3 Black, Latino, and American Indian Alaska Native students.[1] Each of these are aspects of inequity that negatively impact the ability of students to thrive and too many of these and others pre-dated the pandemic, so they are not easily dismissed as being only of this particular moment.

Each of these inequities make it disproportionately difficult for students of color to access a high-quality education this school year, but the systematic denial of educational opportunities to African Americans and other vulnerable students has long subjected many students to an inferior education from the start. Inequities in K-12 education stem from 400 years of systemic racism and federally-sanctioned discriminatory policies that have denied Black, Latino, and other students of color the right to a free and public education. Slavery, Jim Crow laws, language discrimination, and the *Plessy v. Ferguson* Supreme Court ruling of 1896 declaring separate but equal public schools legal created a second-class system of education for children of color in America. Before *Brown v. the Board of Education* in 1954, Black 4th grade students were using White 2nd grade textbooks.

[1] https://nul.org/news/new-analysis-shows-students-color-more-likely-be-cut-online-learning

Even after the Supreme Court outlawed de jure school segregation with their ruling in that case, many states and localities retaliated, leaving generations of students in subpar schools. A 2016 study by the Government Accountability Office found that segregation in schools is worse than any time since the 1960s.[2] According to the report, high-poverty schools where 75-100 percent of the students were low-income and Black or Latino increased from 9 percent in 2000-2001 to 16 percent in 2013-2014. The report also found that these schools had fewer resources and less access to math, science, and college preparatory courses and disproportionately suspended, expelled, or held back students.[3] Despite the promise of Brown and the Civil Rights Act of 1964, Black and Brown children are still learning in segregated schools and facing discrimination. These historic injustices and their existing antecedents continue to negatively impact the education that students experience in our current school system and the outcomes that schools produce.

We need to be intentional about rooting out the systemic racism and racial inequities in our public education system that has disadvantaged generations of Black students, Latino students, and other students of color. Systemic racism in our nation's schools has robbed resources and opportunities for Black, Latino, and other children of color necessary to succeed. For example, students of color are:

- more likely to attend high poverty schools than their White peers;[4]
- less likely to have access to high rigor courses like AP, IB, and STEM;[5]
- less likely to have access to high-quality teachers;[6]
- less likely to have access to high speed internet and technological devices;[7]
- less likely to have social and emotional learning supports and positive behavioral interventions;[8]
- and more likely to have police and/or school resource officers than guidance counselors.[9]

This historical context, coupled with the ways by which too many students of color have borne the brunt of the pandemic, we have seen estimates that Black students have lost an average of 10 months of instruction and Latino students have lost an average of 9 months of instruction since the pandemic began and interrupted in-person teaching and learning, compared to an average of 6 months of lost instruction for White students.[10] Not only did kids lose access to

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[2] https://www.gao.gov/products/gao-16-345
[3] https://www.gao.gov/products/gao-18-258
[4] https://www.epi.org/publication/schools-are-still-segregated-and-black-children-are-paying-a-price/
[5] https://www.jbhe.com/2019/08/the-racial-gap-in-participation-in-high-school-ap-ib-and-dual-enrollment-programs/
[6] https://www.epi.org/publication/the-teacher-shortage-is-real-large-and-growing-and-worse-than-we-thought-the-first-report-in-the-perfect-storm-in-the-teacher-labor-market-series/
[7] https://nul.org/news/new-analysis-shows-students-color-more-likely-be-cut-online-learning
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5142755/
[9] https://tcf.org/content/commentary/school-policing-racially-discriminatory/?agreed=1
[10] https://www.mckinsey.com/~/media/McKinsey/Industries/Public%20and%20Social%20Sector/Our%20Insights/COVID-19%20and%20student%20learning%20in%20the%20United%20States%20The%20hurt%20could%20last%20a%20lifetime/COVID-19-and-student-learning-in-the-United-States-FINAL.pdf

their classrooms, teachers, and classmates overnight, but they lost meaningful access to school meals, school counselors and social workers, and other wrap around services and supports that often provided them with much-needed stability.

As has always been the case in moments of crisis, our Urban League affiliates stepped up to offer opportunity and to fill gaps where they could. Local Urban Leagues have been instrumental in distributing meals to students in their communities who needed them. To address the homework gap, Urban Leagues across the country have led the charge to connect their families – in fact, the Urban League of Metropolitan Seattle began handing out devices to the youth in their programs literally within a day of schools closing. Urban League programming has helped families affected by layoffs find new work. Our affiliates have worked hard to help those in danger of foreclosure and eviction to address housing instability. Lastly, Urban League affiliates have partnered locally with schools, cities, and communities to host COVID-19 testing sites and COVID vaccine sites.

We thank the President and members of the House and Senate for the American Rescue Plan, which, among many needed supports, includes the largest federal investment in education in our nation's history. The unprecedented $200 billion dollars of combined aid from coronavirus relief packages passed so far is much needed, and must be used to work to close persistent and exacerbated equity gaps in our education system. Resources are needed to focus on accelerating learning, not on an overly restrictive remedial approach; to extend learning and development by truly engaging community partners before and after school; to use summer differently both this summer and next to broaden and deepen opportunity; to make sure all students have reliable computer devices and internet access; and to support the whole child with resources like mental health counselors and trauma-informed teachers, and approaches that recognize that student learning and development has continued over the past year even without daily instruction. Given what we have faced over the past 12 months, how could it be otherwise?

The current federal education law, the *Every Student Succeeds Act (ESSA),* required every state in the union to put together a specific plan as to how they would integrate equity into the education of children. In 2019, the National Urban League published a review of ESSA state plans in the 36 states and District of Columbia with local Urban Leagues. In the report, we graded states on 12 key equity indicators and found that nearly a quarter of state plans (8 states) missed significant opportunities to advance equity in their plans. 20 state plans were only "sufficient" in advancing equity. Ultimately, states have implemented their plans with varying levels of fidelity and impact. And this all happened before the novel coronavirus severely impacted how teachers could teach and how students could learn.

Last school year, the federal government waived the part of ESSA that requires annual statewide assessments -- a necessary move at that point. But since then, states had to create and implement plans for how to deliver instruction and make sure students have access to the supports they are entitled to in order to learn. This year, the Department of Education has decided not to waive the testing requirement across the board again, which we support.

Assessment data is one tool in the toolbox to advocate for and advance equity in education. The data from statewide assessments and other sources will inform states, districts, and schools on how best to use the necessary influx of federal COVID-19 relief dollars that they are receiving. In addition, each state and local district was responsible for designing and implementing a plan for delivering an equitable and excellence education to all students. Assessments and other indicators of student success will allow us to see what has worked over the past year, and what hasn't. Where did the nation fall short and what innovations should we carry forward? While the Department's decision to allow time-limited flexibility on the accountability provisions in ESSA will ensure that the data is used only to inform state and local education leaders to make equitable decisions, data from statewide assessments will help inform parents, caregivers, and community stakeholders how their children are performing and how systems are supporting their learning and development. National PTA published a statement that shows that 52% of parents support end-of-year assessments to know if their children are learning and 60% are worried that their child is behind and want information on where their child is academically.[11]

Ultimately, we have an opportunity to address inequity in K-12 education like never before, with an investment by the federal government equal to 8 years of annual Title I funds. Without question, we also need to find the students who schools and districts have lost contact with since March 2020. Whether you believe that this is less than 10% of students or closer to 30% of students as has been reported, I think we can all agree that a single student disconnected from their education and from critical supports is one student too many. This was true before the pandemic and remains true today.

As we look at how the COVID-19 pandemic has widened opportunity gaps, we also need to look at how to recover, how to close resource gaps, how to introduce additional innovation and supports to students, and how to provide our Black and Brown children with a high-quality education.

For the Urban League Movement, a high-quality or excellent education includes equitable access to mental health supports including school counselors, social workers, and strategies that allow educators to recognize the learning and development that did take place over the past year, to build the wellness assets and address mental health needs of adults and students alike during and after a very traumatic year and more. Our education vision also includes ensuring students are learning in safe and healthy schools and getting devices and internet connections into the hands of all students and families who are without it in order to close the homework gap. A high-quality education includes extended learning opportunities both after school and over the summer so students can deepen their intellectual, social, and emotional learning. An excellent education includes expanding the provision of rigorous coursework for students of color and low-income students, who have never had equal access to AP, IB, and STEM classes. It includes access to diverse and qualified teachers and school leaders, whose pedagogy and leadership is culturally-relevant and resonant. And the education that we envision

[11] https://www.pta.org/home/About-National-Parent-Teacher-Association/PTA-Newsroom/news-list/news-detail-page/2021/02/22/national-survey-finds-majority-of-parents-support-end-of-year-state-assessments-with-modifications-and-resources

and for which we advocate includes restorative practices, social-emotional learning, and positive behavioral approaches that don't rely on exclusionary discipline and instead keep Black, Latino, and Native students deeply connected to educators and to rich learning opportunities. In our minds, an excellent education begins by understanding that all learning is social and emotional and deeply reliant on positive relationships, is supportive of development and growth, and grounded in principles of equity. Lastly, and most important, the Urban League envisions our nation fulfilling the promise of *Brown* to combat persistent segregation and discrimination in K12 education, and robust enforcement of civil rights laws.

Thank you for your focus on this issue. I look forward to answering any questions members of the subcommittee have.

Chairman SABIAN. Thank you very much Mr. Morial. And I'd like now that we all hear from Ms. Jennifer Dale please, five minutes Ms. Dale, welcome.

STATEMENT OF MRS. JENNIFER DALE, PARENT

Mrs. DALE. Thank you. Thank you. Good afternoon, Chairman Sablan, Ranking Member Owens, and Members of the Early Childhood, Elementary, and Secondary Education Committee. Thanks for inviting me to testify at today's hearing, "Lessons Learned: Charting the Path to Educational Equity Post-COVID–19."

I really appreciate the work you're doing and being invited to testify. I am the proud and grateful parent to three school-aged chil-

dren. My oldest daughter Maddi is in the 7th grade, and she became a teenager this past February. My youngest child is Charlie, he's 8 years old and in the 2d grade.

My middle daughter is Lizzie, age 9 in the third grade, and she has Down Syndrome. But I'd like to focus most of my testimony on Lizzie, because I feel like she is a hidden victim of pandemic closures and policies and the prolonged school closures that have occurred.

Because of Lizzie and other students like her, I believe that school provide essential services to our communities and should have reopened in the fall of 2020. The pandemic-related shutdown of our school, the co-curricular activities and the youth sports caused major disruptions and destabilization for our children, many of whom could bear it the very least.

And whether it was their intended purpose or not, America's public schools from the basis of our communities and deliver services and experiences that really can't be obtained anywhere else.

For my daughter Lizzie, school is where she participates in physical education and recess. It's where she receives essential therapies such as speech and occupational therapy. School is where Lizzie spends time with friends forming a community bond, so it will ultimately lead to long-term relationships and potential job opportunities for her.

In her IEP, her learning specialist describes Lizzie as a 3d grade student with a big heart, a great sense of humor, who enjoys playing with friends. She's a loyal friend who stands up for peers when they have been wronged or hurt. Lizzie loves to laugh and giggle, and she participates in soccer and dance, and can be a fierce competitor when it comes to sports.

In a typical year, Lizzie spends more than 80 percent of her day in the general education classroom. It is a seat that she has fought very hard to win and to keep. She rides our neighborhood school bus. She's greeted by friends at school who help walk her to class. They help her with hanging her backpack and make her lunch selection.

Over the years being included in the classroom has enabled Lizzie to learn these key routines and build a community for what she is part of the essential fabric. It's this community that she is loyal to. In a typical year, an educational aid supports Lizzie's general education by modifying her classwork and helping develop her reading and writing skills with hands on supports.

But as you know 2020 was not a typical year. Oregon's Governor rightfully shuttered school buildings last March a year ago, when we knew very little about COVID–19. But then the Governor's mandate kept our schools closed under metrics that were so hard to meet that the only path to reopening has been to change the metrics themselves, rather than meet the metrics.

Unfortunately, once schools closed, Lizzie's entire existence seemed to vanish from sight. No one could really see her but me, her father, and her siblings. No one could benefit from that fierce soccer competitor, or that friend who would bring you a band-aid when you are hurt.

No one could see my daughter Lizzie. When distance learning started in September, we were provided with a Chromebook and

several Zoom links for a log-in to Google classroom. And like her peers, Lizzie was supposed to receive all of her instruction online.

But unlike her peers, Lizzie's learning online was not possible. She's still learning sight words, learning to type on a keyboard and learning to use a mouse. Lizzie's frustrations maxed out very quickly, and by the third week she had actually thrown away the Chromebook without us knowing and asked for a faraway school with her friends, which is what she called in-person learning.

For the last 7 months, Lizzie has not been a part of any general education classroom that we fought so hard for her to be in since kindergarten. She had to stop attending general education classes entirely because they were all delivered online.

Back in October I was beginning to wonder how other families were doing this, so I posted my concerns online. My posts formed the beginning of Oregon's grassroots back to school efforts, and a launch of numerous local advocacy groups. We have held rallies almost weekly, hosted Zoom town halls, and initiated massive email campaigns to share our research and the science on the safe reopening with school board Members, superintendents, and lawmakers.

For 1 year Lizzie has been denied all physical, occupational and speech therapies provided under her legal IEP because services are telehealth only, and they continue to be that way even after all educators have been vaccinated. She has been denied services mandated by her IEP.

Maybe this was a temporary experience and hardship for some, but not for Lizzie. And this week we completed the paperwork to hold her back in the third grade where she'll be forced to make all new friends.

Chairman SABLAN. My goodness, such a wonderful story Ms. Dale. I must however—

Mrs. DALE. I understand, I understand.

Chairman SABLAN. I want to continue.

Mrs. DALE. I will be grateful to answer any questions when you're ready.

Chairman SABLAN. All right. Thank you, Ms. Dale, thank you very much.

[The prepared statement of Mrs. Jennifer Dale follows:]

PREPARED STATEMENT OF JENNIFER DALE

Testimony of Jennifer Dale, Parent from Lake Oswego, Oregon
United States House of Representatives
Early Childhood, Elementary, and Secondary Education Subcommittee Hearing
"Lessons Learned: Charting the Path to Educational Equity Post-COVID-19"
Thursday, March 25, 2021, at 1:00 p.m. (EDT)

Good afternoon, Chairman Sablan, Ranking Member Owens and Members of the Early Childhood, Elementary, and Secondary Education Subcommittee. Thank you for inviting me to testify at today's hearing, "**Lessons Learned: Charting the Path to Educational Equity Post-COVID-19**."

I appreciate the work you are doing to evaluate the needs of our children and the impacts of prolonged school closures on their education and educational equity.

I am the proud and grateful mom to three school-aged children. My oldest daughter Maddi is in 7th grade and became a teenager this past February. My youngest child is Charlie. He is 8 years old and in the 2nd grade.

My middle daughter is Lizzie, age 9, in the third grade, and Lizzie has Down syndrome. I want to focus most of my testimony today on Lizzie. She is a hidden victim of pandemic policies and prolonged school closures.

Because of Lizzie and other students like her, I believe schools provide essential services to our communities and should have reopened in the Fall of 2020.

The pandemic-related shutdown of schools, co-curricular activities and youth sports caused disruptions and destabilization for our children, many of whom could bear it the very least. Whether it was their intended purpose or not, America's public schools form the basis of our communities and deliver services and experiences that cannot be obtained anywhere else.

For my daughter, school is where she participates in P.E. and recess. It is where she receives essential therapies, including speech and occupational therapy. School is also where Lizzie spends time with friends, forming the community bonds that lead to long-term relationships and ultimately job opportunities.

In her IEP, or Individualized Education Program, Lizzie's learning specialist describes her as:

"A 3rd grade student with a big heart, a great sense of humor, who enjoys playing with her friends. She is a ***loyal*** friend who stands up for peers when they have been wronged or hurt. Lizzie loves to laugh and giggle. She participates in soccer and dance. She can be a fierce competitor when it comes to sports."

In a typical year, Lizzie spends more than 80 percent of her day in the general education classroom. It is a seat she has fought hard to win and keep.

She rides our neighborhood school bus; she is greeted by friends at school who walk with her to class; she hangs her backpack and makes a lunch selection. Over the years, being included in the classroom has enabled Lizzie to learn key routines and build a community for which she is part of the essential fabric. For whom she is ***loyal***.

In a typical year, an educational aide supports Lizzie's general education, modifying her classwork and helping her develop reading and writing skills with hands-on supports.

But 2020 was not a typical year.

Oregon's governor rightfully shuttered school buildings in March when we knew very little about COVID-19. But then the governor's mandate kept schools closed under metrics so hard to meet that the only path to reopen would be changing the metrics themselves rather than meeting them.

Unfortunately, once schools closed, Lizzie's entire existence seemed to vanish from sight. No one could see her but me, her father and her siblings. No one could benefit from that fierce soccer competitor or that friend who brought you a band-aid when you were hurt. No one could see Lizzie.

When distance learning started in September, we were provided a Chromebook, several Zoom links and a login for Google classroom. Like her peers, Lizzie was supposed to receive all instruction online.

But unlike her peers, we quickly discovered that Lizzie's cognitive delays made online learning impossible. She is still learning site words, learning to type on a keyboard, and learning to use a mouse.

The online platform didn't work to teach her to grip a pencil or correct her answers on a math worksheet. She was confused why the teacher could not hear her or why her peers did not wave hello to her.

To help at home in the absence of an aide, we hired a nanny so that I could continue working as a CPA and my husband in his law practice. But it took three of us to support 2.5 hours of daily Zoom learning. I remember mornings where I had Lizzie on my lap with my arms wrapped tight around her stomach just to keep her from running away. Our nanny sat beside me and my husband by the door. Most mornings I was in tears, and so was Lizzie.

Lizzie's frustrations maxed out quickly.

By the third week, Lizzie threw the Chromebook away without us knowing and asked for "far away school with her friends," as she called in-person learning. For the last seven months, Lizzie has not been part of the general education classroom we fought so hard for since kindergarten. She stopped attending general education classes entirely.

We sent video clips to the principal, the superintendent and school board members. They said their hands were tied. But we pushed and pried open the doors in mid-October. Lizzie was the first student in our district (and the entire metro area) to return to something called "limited in-person" by the Oregon Department of Education.

But it was very limited. No teachers. No therapies. No friends. Just two hours, two times per week.

This was back in early October and I was beginning to wonder how other families were doing it. I posted my concerns online, sharing this post on Facebook:

"I'm ready to tell anyone who will listen that it's time to go back to school, in-person. This was a heroic effort by our schools, administrators and teachers, but families are not OK.

Kids are not OK in this model.... at the very least, our most vulnerable and our youngest kids need to be back in school. It's time to begin learning to live with Covid as we have at grocery stores, restaurants, and more. We can't hide forever."

That post formed the beginning of Oregon's grassroots back-to-school efforts and the launch of numerous local advocacy groups. We have held almost weekly rallies, hosted Zoom town halls, and initiated massive email campaigns to share research and science on safe reopening with school board members, superintendents and lawmakers. We found that it was very difficult to get anyone to listen and work with us to reopen schools. Somehow, it was no one's fault and everyone's fault. And kids were being harmed while adults debated what to do.

For one year, Lizzie has been denied all physical, occupational, and speech therapies provided under her legal IEP because services are telehealth only, even now after all educators were prioritized for the vaccine. She has been denied services mandated by her IEP.

She has lost every single friendship we built from kindergarten because there are no classrooms with peers and no sports or extracurricular activities. A once vibrant life full of dancing on stages, scoring goals in soccer, and friends who helped her open her lunchbox, gone.

The importance of in-person, general education classrooms in my daughter's life could not be more critical.

- In a classroom, Lizzie joins reading groups where students take turns reading to her and she reads to them.
- In a classroom, Lizzie's aide monitors whether she needs a quick walk-about to reset her overwhelmed thinking.
- In a classroom, Lizzie's friends stay alert to when she needs help cutting a piece of paper.
- In a classroom, Lizzie's teacher provides specialized seating so that she can stay on task.

Maybe this is a temporary experience and hardship for some but not for Lizzie. This week, we completed the paperwork to hold Lizzie back in the third grade; she will be forced to make all new friends.

Therefore, even as schools begin reopening, it does not mean things are returning to "normal" for our family, or many others. In fact, the *prolonged closure of public schools* has dramatically changed just about every aspect of our lives, especially for my kids. Even after a year of people telling parents: don't worry kids are resilient, or all kids will be behind – the truth is everyone had to figure out for themselves how to solve this problem.

My oldest now attends a private Christian school from 8am to 3pm; my son now goes to an independent private school from 8am to noon each day; and Lizzie attends 8 to 10:45 then again 2 to 2:30pm for specialized instruction. My most vulnerable learner is still receiving the least amount of instruction.

The harms that have occurred due to the prolonged closures of public schools have fallen hardest on our most vulnerable children. School closures have divided communities and families. In closing, I wanted to share something that Lizzie asked us last week at morning drop off: "Please ask my brother, Charlie, to come back to my school with me." She wants her siblings, her friends and her community to come back together, and I think we all want to figure out how to do this in a way that serves our most vulnerable children.

Chairman SABLAN. And next we'll hear from Selene Almazan, I hope I do justice with that name. Ms. Almazan you have five minutes please.

STATEMENT OF SELENE A. ALMAZAN, ESQ., LEGAL DIRECTOR, COUNCIL OF PARENT ATTORNEYS AND ADVOCATES, INC.

Ms. ALMAZAN. Thank you. Good afternoon, Chairman Scott, Chairman Sablan, Ranking Member Foxx, Ranking Member Owens, and Members of the subcommittee. I am Selene Almazan, legal director for the Council of Parent Attorneys and Advocates, COPAA, and I am also a parent.

Two of my three children have disabilities and attended Maryland public schools. On behalf of COPAA I appreciate the opportunity to testify today.

COPAA is a national nonprofit organization of parents, attorneys, advocates, and related professionals who work to protect the civil rights and secure excellence in education on behalf of the 7.7 million children eligible for special education under the Individuals With Disabilities Education Act, IDEA, and the 1.4 million students with disabilities protected by Section 504 of the Rehabilitation Act.

I want to start with what equity is and why it matters. Equity and equality are not the same. While equality means treating every student the same, equity means making sure that every student has the support they need to be successful. Equity and education require putting systems in place to ensure that every child has an equal chance for success.

Our education and disability laws are civil rights laws, and you can see my written testimony for a full discussion of each. The IDEA was enacted in 1975 and it is a civil rights and access law which governs how states in U.S. territories provide early intervention and special education to eligible children from birth to age 21.

Section 5.04 prohibits discrimination and ensures equal access to an education for individuals with disabilities. The Americans With Disabilities Act is also critical to people and students with disabilities. The Elementary and Secondary Education Act, ESEA, promotes educational achievement and protects the interests of students, disadvantaged by poverty, disability, ethnicity, race, and other conditions that may limit occupational opportunity.

A few datapoints provide understanding of who children with disabilities are, and the statute of State funding to educate them. Students with disabilities represent 14 percent of public school enrollment. 74 percent of 4th grade students with disabilities scored below basic in reading in 2019, compared with 29 percent of students without disabilities.

Black students with disabilities represent 18 percent of students with disabilities, yet account for 35 percent of students with disabilities who are suspended or expelled from school. Congress has never come close to providing the IDEA funding promised to States.

And States offset billions annually, details are in my written testimony. The COVID–19 outbreak has placed a tremendous, unprecedented strain on States, districts, educators, families, and students. In spring 2020 you and other congressional champions helped ensure that Congress did not provide States the ability to waive the requirements and protections of the IDEA. Thank you.

This action, combined with guidance from the department reminding States and districts of their obligations to provide students with disabilities in education, helped steer several misguided districts, and a handful of states back into compliance. We do not believe however, that sufficient guidance has been provided on the issue of parents opting their children out of in-person schooling, as was done during the H1N1 virus.

Students may be medically fragile, live with a loved one who is, or have an intellectual disability that interferes with their ability

to keep COVID–19 safety guidelines. No student should be deprived of IDEA services because the student's family or physician does not think it is safe to return to school.

COPAA formally asked the department to provide clarifying guidance last summer. This February, with 40 civil rights, disability, business, and educational organizations, COPAA thanked the department for the decision to uphold the ESEA and require States to conduct state-wide, annual assessments.

We said, 'Data on multiple measures are essential tools to address systemic inequities in our education system as well as to gauge the quality of instruction and support offered under COVID–19 restrictions."

To ensure equity and support of America's students we make the following recommendations: Fully fund the IDEA and Title I of the ESEA and provide funds to help eliminate the shortages of counselors, social workers, nurses, school psychologists and well-trained fully certified special education teachers.

Provide oversight, so COVID–19 stimulus K to 12 funding includes and will also address the learning loss of students with disabilities. Support the department to help States administer summative state-wide assessments. Pass bills dedicated to improving school climate, and end the use of exclusionary discipline, including seclusion and restraint such as the Keeping All Students Safe Act, and provide oversight to ensure the department is equipped to enforce the equity in IDEA regulations.

We must ensure that all students impacted by COVID–19 because of disability, race, ethnicity, foster care status, homelessness, and poverty, are given resources to recover learning losses and ensure equity for all. I look forward to your questions, thank you.

[The prepared statement of Ms. Selene A. Almazan, Esq., follows:]

PREPARED STATEMENT OF SELENE A. ALMAZAN

Testimony on:
Lessons Learned: Charting the Path to Educational Equity Post-COVID-19

Subcommittee on Early Childhood, Elementary and Secondary Education
U.S. House of Representatives

By:
Selene Almazan, Esq., Legal Director
Council of Parent Attorneys and Advocates (COPAA)

Good afternoon Chairman Scott, Chairman Sablan, Ranking Member Foxx, Ranking Member Owens, and members of the subcommittee, I am Selene Almazan, legal director for the Council of Parent Attorneys and Advocates (COPAA) and I am also a parent. Two of my three children have disabilities and attended Maryland public schools. On behalf of COPAA, I appreciate the opportunity to testify today.

COPAA is a national nonprofit organization of parents, attorneys, advocates, and related professionals who work to protect the civil rights and secure excellence in education on behalf of the 7.7 million children ages 0 through 21 eligible for special education services under the *Individuals with Disabilities Education Act* (IDEA) and the 1.4 million K-12 students with disabilities protected by Section 504 of the Rehabilitation Act across the United States. I appreciate the opportunity to testify and hope to work with the committee to discuss and develop proactive policy solutions that keep equity for students at the center of Congress' work and to support the oversight activities and vital funding needed to promote, protect, and support children with disabilities from birth to college, career training and employment while putting an end to any form of discrimination.

Equity and Why It Matters to Students with Disabilities

Much has been made of the difference between equity and equality. While equality means treating every student the same, equity means making sure every student has the support they need to be successful. Equity in education requires putting systems in place to ensure that every child has an equal chance for success. Whether we are talking about disability, race, socioeconomic status, city of residence, or any number of intersections of identities, we know that identity plays a significant role in the access and opportunities available to people in this country.

COPAA recently finished our 2020 Virtual Summit and our opening keynote, Kori Hamilton Biagas founder of Just Educators, eloquently stated the struggle when she said:

> …people with disabilities have been fighting for access, support, and protections to be able to receive education in the least restrictive environment without being restrained or excluded, to be able to move about the country and the world freely, to be seen as people

first, who are capable of contributing to and leading in our society. Now, fortunately, we have evolved from the age when our children with disabilities were fully excluded from school and other parts of our society. But many of those stigmas and stereotypes remain part of the fabric of our society. And although many of our students with disabilities are able to attend school, we still often find them segregated, whether they're self-segregating as Senator Murphy shared that story, where a student is removing himself from the class because he is not receiving the supports that we need, and he is feeling humiliated and isolated. Or whether they're relegated to some bungalow in the back of the campus somewhere. And the pandemic has just exacerbated these challenges and stress that are associated with physical and emotional care. [In this time] we must lean in even more deeply to the provisions provided under the Civil Rights Act, IDEA, ADA, Title II, Title VI, Title IX, and discrimination laws so our students can get what they need, even in a pandemic, and especially in a pandemic[1].

Civil Rights Protections and Educational Promise Under Federal Law

Our nation's civil rights and education laws work in concert to support individuals with disabilities to have equitable access to and benefit from not only their education, but to all aspects of society. I will provide a basic overview of each law including the Civil Rights Act, the IDEA, Section 504, the Americans with Disabilities Act and the Elementary and Secondary Education Act (ESEA) currently known as the Every Student Succeeds Act.

The Civil Rights Act of 1964 enacted July 2, 1964 is a landmark civil rights and labor law that outlaws discrimination based on race, color, religion, sex, national origin, and later sexual orientation and gender identity[2]. It prohibits unequal application of voter registration requirements, racial segregation in schools and public accommodations, and employment discrimination. Many agree that the act remains one of the most significant legislative achievements in American history.

The IDEA enacted in 1975 is a civil rights and access law which governs how states, U.S. Territories (herein collectively referred to as "states") and public agencies provide early intervention, special education and related services to eligible infants, toddlers, children, and youth with disabilities. IDEA ensures states do the following:

1. **Conduct Child Find to ensure that all children with disabilities from birth through age 21 and are in need of special education and related services are identified, located, and evaluated. This includes children who are homeless or are wards of the state, children attending private schools, as well as migrant children.**

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[1] COPAA 2021 Virtual Summit Keynote Address at www.copaa.org

[2] Reference at: https://en.wikipedia.org/wiki/Civil_Rights_Act_of_1964#cite_note-4

2. **Provide a free appropriate public education (FAPE) to eligible children with disabilities ages 3-21 under *IDEA* Part B and early intervention services to infants and toddlers with disabilities birth through thirty-six months and their families under *IDEA*, Part C.**

3. **Ensure parents understand the civil rights of their children with disabilities under the law.**

Each state is required to establish regulations aligned with the federal law to help schools determine whether a child is eligible for special education under one or more of the IDEA's 13 disability categories which include: autism; deaf-blindness; deafness; emotional disturbance; hearing impairment; intellectual disability; multiple disabilities; orthopedic impairment; other health impairment; specific learning disability; speech or language impairment; traumatic brain injury; or visual impairment.

Once a child is found eligible, IDEA requires the child's parent, or legal guardian to be an integral part of the team responsible to develop the child's Individualized Family Service Plan (for children ages 0 through 2) and the Individualized Education Program (IEP) (for children ages 3-21); herein referred to as the IEP. Parents[3] play a vital role as they know their child best and can help the team decide the specially designed instruction, supplementary aids, interventions, related services, accommodations and other supports a child needs to succeed. Since the law's inception, parents and schools have engaged in a process to develop a child's IEP that in the best of circumstances assures the child receives the services required but in the worst of circumstances can result in a legal battle over the appropriateness of the child's IEP.

Importantly, in the unanimous 2017 *Endrew F.* decision Chief Justice Roberts noted, IDEA requires IEPs "will be informed not only by the expertise of school officials, but also by "the input of the child's parents and guardians." The IEP is reviewed annually by the IEP team and provides the roadmap for schools to provide individualized supports and services and for families to be assured a plan unique to their child is in place. "School authorities should offer a "cogent and responsive explanation for their decisions." The *Endrew F.* decision also highlighted important aspirations to promote equity, stating that each child with a disability needs to have "appropriately ambitious goals, a chance to meet challenging learning objectives…an IEP that is reasonably calculated to enable a child to make progress appropriate in light of the child's circumstances." Also, "IEP goals must be aligned with grade level content standards for all children with disabilities, and…for most children, a FAPE will involve integration in the regular classroom and individualized special education calculated to achieve advancement from grade to grade."[4]

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[3] Parents includes natural, adoptive, or foster care parents, legal guardians, surrogate parents. 20 U.S.C. 1401 (23).

[4] *Endrew F. v. Douglas County School District RE–1*, 580 U.S. ___ (2017) at: https://www.justice.gov/crt/file/887601/download

As is clear from its title, the IDEA is a person-centered law, in which the educational program for each student is individualized for that student's needs. The law explicitly rejects a one-size-fits-all approach to the education of students with disabilities.

Section 504 is a civil rights law under the Rehabilitation Act of 1973 that prohibits discrimination against individuals with disabilities. Section 504 ensures that the child with a disability has equal access to an education. While a child not eligible under the IDEA may receive accommodations and modifications to support their access to an education through Section 504, all students eligible under the IDEA enjoy the anti-discrimination protections of Section 504. The U.S. Department of Education's Office for Civil Rights is responsible to ensure there is no discrimination.

The ADA passed in 1992 and amended in 2008 prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations (including in higher education), commercial facilities, and transportation. Both ADA and Section 504 provide that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities provided by the school district[5]. For purposes of students in elementary and secondary education in government-funded schools, the protections of the ADA and 504 are identical.

The Elementary and Secondary Education Act (ESEA) currently known as the Every Student Succeeds Act was passed in 1965 and is our nation's most important civil rights law for promoting educational achievement and protecting the rights and interests of students disadvantaged by discrimination, poverty, disability, ethnicity/race, and other conditions that may limit their educational opportunity. Students with disabilities have benefited greatly from the ESEA's focus on student outcomes which since 2001 has included students with disabilities as one of the four student subgroups included in state assessment, reporting and accountability systems. As a result of the alignment between ESEA and the IDEA, more students with disabilities have been afforded the opportunity to learn and master grade level academic content, have been meaningfully included in statewide assessment systems and to have achieved key academic outcomes including graduating from high school with a regular diploma.

Education Funding

When IDEA became law in 1975, Congress promised to provide 40 percent of the annual per pupil expenditure (APPE) to assist districts with the cost of providing a FAPE to eligible students. Outside of a doubling of funds under the American Recovery and Reinvestment Act in 2009 for one-time use, annual federal appropriations have never exceeded 18 percent [in 2005] yet the number of students served and the national average per pupil expenditure have continued to rise. Currently, Congress funds IDEA at about 13 percent of the APPE. For Fiscal Year (FY)

[5] 28 CFR Sec. 35.130, 34 CFR Sec. 104.4

2021 Congress has provided a total of $16.7 billion for IDEA, including an additional $2.5 billion provided through the American Rescue Plan. This level of funding however still requires states and districts to make up for the $21 billion gap in federal funding for this school year alone. The ongoing decline of federal contribution to the costs of educating students with disabilities coupled with the pandemic, has illuminated what the unfortunate funding gap means – that students with disabilities are in greater jeopardy of losing access to the instruction, services, interventions and supports they need.

Title I of the ESEA has also been critically underfunded since its passage in 1965. These funds are relied upon by public schools that educate children in lower income neighborhoods. Title I provides resources key to districts and schools in meeting the requirements and purpose of ESEA which is to "**provide all children significant opportunity to receive a fair, equitable, and high-quality education, and to close educational achievement gaps.**"[6] **In FY 2019, Title I was underfunded by $29 billion[7].**

Children with Disabilities

Students with a wide range of disabilities, including intellectual disabilities, are making great educational strides including meaningful academic and social gains alongside their peers. This is the purpose of the IDEA – to provide for the education of all children with disabilities and the promise is that all students with disabilities, no matter their challenge, can graduate ready to enter post-secondary education and/or gain career skills that lead to an independent and meaningful life.

A few data points can ground us in understanding who children with disabilities are:

- Students with disabilities served under IDEA represent 14% of the public-school enrollment[8] and another 2.7% are served under Section 504.
- The number of IDEA-eligible children has grown by 462,000 students between 2015-2019[9] an increase of almost 7 percent while total school enrollment has barely increased[10].
- 74% of 4th grade students with disabilities scored *below basic* in reading on the 2019 National Assessment of Educational Progress (NAEP), compared with 29% of students without disabilities[11].

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[6] Sec. 1001. 20 U.S.C. 6301

[7] National Education Association Federal Funding Guide, 2020 at: https://www.nea.org/resource-library/esea-title-i-part-grants-local-educational-agencies-leas

[8] *42nd Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act*, 2020, Office of Special Education and Rehabilitative Services, U.S. Department of Education

[9] Ibid.

[10] Projections of Education Statistics to 2028, National Center for Education Statistics, U.S. Department of Education at: https://nces.ed.gov/programs/PES/section-1.asp#2

[11] Nation's Report Card, 2019 National Assessment of Educational Progress at: https://www.nationsreportcard.gov/

- On average, just 11% of high school students with disabilities score proficient on state assessments in reading and only 7% in math[12].
- 29% of students with disabilities were subjected to some form of disciplinary removal[13].
- Black students with disabilities represent 18% of students with disabilities yet account for 35% of students with disabilities suspended or expelled from school[14].
- 78% of students subjected to seclusion are students with disabilities[15].
- Black students comprise 15% of the student population yet they represent 22% of students subjected to seclusion and 34% of students subjected to mechanical restraint[16].
- 67.1% of students with disabilities graduate from high school with a regular diploma as compared to 85% of students without disabilities[17].

With these important data in mind, my testimony today intends to accomplish two priorities:

1. Underscore the disparate impact of COVID-19 on students with disabilities and outline the key role the U.S. Congress and the U.S. Department of Education (Department) play in ensuring requirements of federal education and civil rights laws are upheld**;** and,
2. Make recommendations to ensure equity for students with disabilities during the pandemic and beyond.

1. Underscore the disparate impact of COVID-19 on students with disabilities and outline the key role the U.S. Congress and U.S. Department of Education play in ensuring requirements of federal education and civil rights laws are upheld.

The COVID-19 outbreak has placed a tremendous and unprecedented strain on states, districts, educators, families, and students. Despite the challenges facing us all, we know students with disabilities are best served when diverse stakeholders come together and share resources, innovative ideas, and promising practices. For many students and their school teams this was the case. Since the pandemic hit, COPAA has partnered with the Council of Chief State School Officers, state directors of special education, the Consortium for Citizens with Disabilities (CCD), civil rights advocates, and other partners to develop resources that support and encourage schools and families to work together to find solutions that allow children to receive equitable access to an education and the services that help without weakening or undoing civil and educational rights.

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[12] *42nd Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act*, 2020, Office of Special Education and Rehabilitative Services, U.S. Department of Education

[13] *OSEP Fast Facts: Black or African American Children with Disabilities*, 2019, U.S. Department of Education, EDFacts Data Warehouse (EDW): "IDEA Part B Child Count and Educational Environments Collection," 2018-19. http://go.usa.gov/xdp4T

[14] *42nd Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act*, 2020, Office of Special Education and Rehabilitative Services, U.S. Department of Education

[15] Civil Rights Data Collection, 2018, U.S. Department of Education at: https://www2.ed.gov/about/offices/list/ocr/docs/restraint-and-seclusion.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

[16] Ibid.

[17] Common Core of Data, National Center for Education Statistics at: https://nces.ed.gov/ccd/tables/ACGR_RE_and_characteristics_2016-17.asp

In spring 2020, you and other Congressional champions for children with disabilities helped ensure that Congress did not provide states or districts the ability to waive the requirements and protections of the IDEA; fully protecting the educational rights and opportunities of all children with disabilities ages 0-21. Thank you. This action combined with guidance from the Department - reminding states and districts of their obligation to provide eligible students with FAPE as embodied in the individualized education program (IEP) - helped steer several misguided districts and a handful of states back into compliance. We had received reports of districts and states withholding educational services altogether or hand-picking which students would be served. Unfortunately, even with the current guidance, we continue to hear of families who when meeting about their child's IEP are asked to waive/sign away their rights to a free appropriate public education and any future rights to compensatory education services. These types of waivers are against public policy and subvert the intention of civil rights laws when students without disabilities are not being asked to sign similar waivers to access hybrid instruction due to COVID-19 closures.

It is important to note, however, that COPAA did not agree with guidance issued by the Office of Special Education on March 12, 2020 stating that school districts do not have to provide FAPE to students with disabilities if they are not providing an education to any student in the district[18]. This position is contrary to years of guidance from the Department and directly violates IDEA including guidance issued by the Department during the Ebola outbreak and in subsequent communications to charter schools which states:

> If a child with a disability is absent from school for an extended period of time because … the school has been dismissed at the request of public health authorities, then school administration officials and the child's IEP Team (or appropriate personnel under Section 504), in collaboration with public health authorities, must determine whether the child is available for instruction and could benefit from homebound services such as instructional telephone calls, homework packets, Internet-based lessons, and other distance-based learning approaches, to the extent available[19].

COPAA recommends the Biden Administration correct this violation of the IDEA by issuing clarifying guidance to ensure students with disabilities do not experience any lag in essential services and supports even when schools may be completely closed due to COVID-19.

FAPE During COVID-19

As the year has unfolded with some states and districts reopening schools, some moving to hybrid learning or others remaining completely virtual, the status of students with disabilities has been in great flux. Even when schools reopened, some parents have opted to keep their child(ren)

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[18]https://www2.ed.gov/about/offices/list/ocr/frontpage/faq/rr/policyguidance/Supple%20Fact%20Sheet%203.21.20%20FINAL.pdf

[19] See: Office of Special Education and Rehabilitative Services, Preparing for Infectious Disease: Ebola Department of Education Questions and Answers on Providing Services to Children with Disabilities During Extended Student Absence or School Dismissal, December 2014

home due to concern about the virus. Multiple factors impact this decision including the student's age, nature of their disability, physical or mental health status, and other risk factors. Many students with disabilities have complex medical issues that make them especially vulnerable to the potential impact of COVID-19. Students of color were far more unlikely to attend in-person school than were white students.

If a parent chooses not to send their student with a disability back to school, the IEP team is obligated to offer a FAPE and appropriate accommodations through distance, hybrid, or home-based learning to the maximum extent possible. While the Department has clarified that FAPE applies to all children with disabilities when an education is being offered to all students during COVID-19, we do not believe that sufficient guidance has been provided on this issue of opting out as was done during the H1N1 virus. COPAA issued a statement[20] in July 2020 and formally requested the Department to provide clarifying guidance as was done during that health crisis. We have shared our request also with the Biden Administration and are hopeful action will be taken on this point.

No student with a disability should be deprived of all special education and related services because the student's family and/or physician does not think it safe to return the student to the school building. Parents and guardians who voluntarily choose for students to temporarily engage in learning from home for any reason need to be supported. In addition to the requirements of the IDEA, the ADA also requires schools to provide reasonable accommodations which may include safe in-person supports as well as equal access to virtual or remote education. The Department should help states develop temporary support options for students who continue remote learning from home, including but not limited to offering families robust educational support and special education which ensures the student is offered FAPE. [21] As stated in the CCD Principles in Reopening Schools,

> …every student and educator who chooses to return to in-person learning must have adequate access to personal protective equipment and other COVID-19 transmission mitigation measures and have the support and training necessary to feel safe in their school. Regardless of where educators and students are teaching and learning—in person, virtually, or in a hybrid setting—schools must ensure students with disabilities have the same instructional and other opportunities as students without disabilities, and to be provided with disability-related accommodations and services if necessary to ensure equitable access in the same range of instructional settings offered to nondisabled students. Districts must continue to provide high-quality educational opportunities and

[20] *Recommendations on the Provision of FAPE When A Parent Opts to Keep Their Child Home From School*, at: https://cdn.ymaws.com/www.copaa.org/resource/resmgr/docs/2020_docs/2ndrecommendations_on_the_pr.pdf

[21] A number of parents of students with disabilities may want to continue with remote learning, either because of the continued presence of the disease or because the student did better without the distractions of school. Guidance will be needed to address these ongoing concerns.

> access in line with federal laws and must meaningfully collaborate with families to provide students the best opportunities for success[22].

Students with disabilities are disproportionately impacted by a lack of access to appropriate technology; limited connectivity to the Internet, no home devices or too few devices for the family. The reality is that many students with disabilities require specialized assistive technology that allows them to 'plug in' and access anything virtual or electronic such as the school website, curriculum and other learning materials, online teacher notes, virtual workgroups and more. Because most students with disabilities use their assistive technology while they are in class, when the school doors closed, they precipitously lost access to the very devices they need to fully participate with their peers in virtual or hybrid learning. So, for these students, their learning loss began immediately on day one. Schools and districts have worked to help these students, but we know that for some, help has not come or it has come extremely late this year.

Teachers and school systems trained in universal design for learning (UDL) -which ensures flexible design of materials and increases accessibility to all learners including students with disabilities, English Learners, students not yet reading at grade level or others – have had greater success in connecting with and engaging their students. We urge states to use their education stimulus funding to equip teachers in evidence-based teaching practices such as UDL, purchase updated assistive technology devices and accessible materials for students with disabilities and update as well as upgrade websites -so they are fully accessible- so that every student can learn regardless of their educational environment.

Statewide Assessment During COVID-19

As noted above, the ESEA is one of our nation's most important civil rights law because it specifically promotes educational achievement and protects the rights and interests of students disadvantaged by discrimination, poverty, disability, ethnicity/race, and other conditions that may limit their educational opportunity. The important intersectionality of the IDEA with the ESEA is critical to ensuring the academic success of students with disabilities.

While the IDEA has required that states assess all students with disabilities since 1997, it was not until the reauthorization of the ESEA in 2002 (known then as the No Child Left Behind Act) and that law's new requirements that states and districts must: assess all students in grades 3-8 and once in high school in reading, mathematics; assess specific student subgroups; and, be held accountable (now according to state-designed systems), that students with disabilities were also included. With this new requirement to assess 95 percent of students under ESEA, including students with disabilities as a specific subgroup, came the availability of academic data on the performance of students with disabilities in schools, districts, and states. This change in federal law also ended the discriminatory and common practice where schools invited children with

[22] *Statement of Principles for Elementary and Secondary Education of Students with Disabilities During the COVID-19 Pandemic*, 2021, Consortium for Citizens with Disabilities Education Task Force at: http://www.c-c-d.org/fichiers/CCD-Ed-TF-Revised-reopening-principles-March-2020.pdf

disabilities to stay home on test day or administered a below grade level test to students rather than ensuring they were included in either a grade level assessment designed against state-set standards or an alternate assessment on alternate grade level standards [for students with the most significant cognitive disabilities]. The historic and practical value of this data to individual families, to advocates and to policy makers cannot be understated and is well documented. We have come a long way since 1997. States have developed valid and reliable reading, math, and science assessments accessible to all students, but as with every hard-won right, sometimes we must be reminded from whence we came. Therefore, we want everyone to know how important it is to continue to require statewide annual assessments and to ensure all students are included. To underscore this point, students with disabilities are general education students first and therefore should be afforded the same educational opportunities.

This February, together, with 40 civil rights, social justice, disability rights, immigration policy, business and education organizations COPAA thanked the Department for the policy decision to uphold core tenets of ESEA and require states to conduct statewide annual assessments and stated, "Data on multiple measures, including school climate, student access to resources and opportunities, and student learning outcomes, are essential tools to address systemic inequities in our education system, as well as to gauge the quality of instruction and support offered under COVID-19 restrictions. with some flexibility."[23] COPAA also told the Department directly,

> [Due to COVID-19]…To remediate for all students and to compensate students with disabilities, we need to know the details of the educational loss. We need to know those areas in which students have failed to progress or have regressed and those areas in which students have held their own. This can only be done through objective, valid testing. As the Department considers requests for waivers of testing by states, it needs to ensure that legitimate methods of assessing present levels of performance of all students are put in place.
>
> For students with disabilities, decisions about the nature and extent of compensatory education need to be made by school teams that include parents, as full members, as a part of updating Individualized Education Plans (IEPs). End of year assessments - in reading and math - inform that conversation. While the pandemic is and continues to pose challenges for schools and families, we also know that states and districts must maintain high standards for education including for children with disabilities. Any action on waivers by the Department must not lower standards and expectations for students with disabilities. Parents of students with disabilities need to know how their children are performing. Having key data on both individual children and subgroups of children is

[23] Response From Civil Rights, Social Justice, Disability Rights, Immigration Policy, Business, and Education Organizations to the U.S. Department of Education's Updated Guidance on Key ESSA Provisions in 2020–21, February 2021 at: https://edtrust.org/press-release/response-from-civil-rights-social-justice-disability-rights-immigration-policy-and-education-organizations-to-the-u-s-department-of-educations-updated-guidance-on-key-essa-provisions-in/

critical to helping schools target resources and interventions and to facilitate remedial learning[24].

Therefore, we encourage the Committee to support the Department as it carefully approves limited waivers of key ESEA requirements for statewide assessment. The Department must ensure states and districts approach data gathering in comprehensive and meaningful ways and do not shirk their responsibilities and obligations under ESEA. To reiterate what we told the Department last month, "Billions of federal dollars are being provided to districts to mitigate the impact of COVID-19, including for instructional loss for all students. It is incumbent upon states and districts to assess where students are and support schools to develop plans to help children with disabilities, through their IEPs, to make up any losses experienced this year."[25]

Exclusionary Discipline and Disproportionality During COVID-19

Schools must be safe havens that facilitate learning for all students. Bullying, discrimination, harassment, racial injustice, aggression, restraint, seclusion, violence, and abuse all defeat education. The data already shared regarding the disproportionate and harsh impact of exclusionary discipline practices used against students with disabilities is alarming; the rash of school shootings is frightening, and schools must take appropriate steps to reduce harsh discipline and prevent further violence including providing a trauma-informed supportive approach to assist parents and students.

The realities pre-COVID-19 regarding the use of harsh discipline against students with disabilities only make the post pandemic world even more bleak. COPAA is concerned because school districts continue to allow the use of punitive discipline approaches that ignore the complex issues that arise when children feel threatened, exhibit challenging coping behaviors, (reactivity, aggression, or social withdrawal) and/or develop clinical disorders. We know of at least one school that inquired about technical assistance in the proper use of protective personal equipment for staff while restraining a student with a disability. There is a sad irony to this given the stress that all are under. COPAA believes that schools must take a whole child and whole school community approach and provide coordination of care as well as restorative justice practices to ensure schools are safe for students and for personnel.

COPAA calls upon Congress to support a bevy of school climate bills that seek to eliminate corporal punishment, out-of-school suspension, expulsion, seclusion, prone, supine, chemical and mechanical restraint, police in schools, and school-based arrests for anything other than a serious felony. This improved school climate can be achieved with staff trained in techniques that are student-centered, trauma-informed, promote social and emotional well-being, and foster student participation in learning. We also call upon schools, districts, and states to examine discipline policies, eliminate zero tolerance codes of conduct, end contracts with law enforcement, and begin an immediate transition away from reliance on school resource officers

[24] COPAA Statement on the U.S. Department of Education Statewide Assessment Flexibility Policy, February 2021.
[25] Ibid.

and other contract police whom research shows do more harm than good.[26] Finally, states and districts need expanded federal funding to eliminate the well documented shortage of well-trained and fully certified special educators as well as specialized personnel including school psychologists, school counselors, nurses, social workers, speech-language/occupational therapists and others integral to the success of students[27].

In March 2019, in *COPAA v. DeVos*[28], the U.S. District Court for the District of Columbia ruled the Department had engaged in an 'illegal delay' of the 2016 Equity in IDEA regulations. Those regulations, which were supposed to go into effect on July 1, 2018, implement the IDEA requirements relating to significant racial disproportionality. The federal court's ruling required the 2016 final regulations to immediately go into effect. Data released this week continues to indicate huge racial disparities in rates of out-of-school suspension among secondary students with disabilities. Perhaps most alarming, Black secondary students in hundreds of large districts are referred to law enforcement at rates that far surpass other students with disabilities from other racial groups and at levels that should raise concerns[29].

COPAA has asked the Biden Administration to ensure states are moving forward to implement the regulations and that both monitoring and data collection occur as required under the law. We encourage Congress to assure that states will be required to help their districts who have historically discriminated against children, especially Black, Hispanic, Native American, Asian and Pacific Islander, and other students who data shows need social and emotional supports and therapeutic intervention services rather than ordering their suspension and expulsion from school.

2. **Make recommendations to ensure equity for students with disabilities during the pandemic and beyond.**

COPAA provides the following recommendations to Congress as it initiates priorities in response to the pandemic and in support of America's students.

- **Fully fund the IDEA and Title I of the ESEA**. As documented, the IDEA and the ESEA are both significantly underfunded. We urge Congress to support a Fiscal Year 2022 budget recommendation that will put IDEA and Title I each on a glide path to full

[26] Criminology and Public Policy: *Effects of school resource officers on school crime and responses to school crime, 2020, U.S. Department of Justice* at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/1745-9133.12512

27 UCLA Civil Rights Project, *National Analysis Details Troubling Levels of Pre-existing Education Inequities for Students with Disabilities*, 2021, at: https://www.civilrightsproject.ucla.edu/news/press-releases/2021-press-releases/national-analysis-details-troubling-levels-of-pre-existing-education-inequities-for-students-with-disabilities

[28] *COPAA v. DeVos* Civil Action No. 18-cv-1636 (TSC) at: https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1636-31

[29] UCLA Civil Rights Project, *National Analysis Details Troubling Levels of Pre-existing Education Inequities for Students with Disabilities*, 2021, at: https://www.civilrightsproject.ucla.edu/news/press-releases/2021-press-releases/national-analysis-details-troubling-levels-of-pre-existing-education-inequities-for-students-with-disabilities

funding. The short-term nature of the money in the ARP does not permit hiring needed staff or instituting strong and sustainable education programs.

- **Expand federal funding to eliminate the shortages of counselors, social workers, nurses, school psychologists and well-trained fully certified special education teachers.** Additionally, Congress must provide incentives for state funding to cover students experiencing trauma and for 504-only students.
- **Provide oversight to assure COVID-19 stimulus K-12 funding includes and will also address the learning loss of students with disabilities**. While roughly $3 billion for the IDEA was included to support special education in the American Rescue Plan, states and districts will need to utilize other K-12 funding to assure students with disabilities are afforded access to the same programs and opportunities as all other students, in addition to receiving special education services according to their IEP. We cannot permit the special education funds included in the ARP to become a ceiling, rather than a floor.
- **Support the Department to help states administer summative statewide assessments.** To understand the effects of the COVID-19 crisis and ensure this pandemic does not undermine the futures of students across the country, we must collect accurate, objective, and comparable data that speaks to the quality of education in this moment, including data from statewide assessments. Without this, state and district leaders will not be equipped with information about the disparate impact of unfinished learning; nor will they be able to equitably allocate resources, personnel, and services that accelerate learning.
- **End the use of seclusion and restraint through passage of the Keeping All Students Safe Act.** As I have noted, the abuse and trauma against students in schools is horrific and a federal law is needed to end it.
- **End exclusionary discipline and eliminate police in schools by passing a suite of school climate bills.** COPAA with civil rights, disability and education partners are collaborating on a suite of bills that comprehensively would: end corporal punishment in schools, prevent and reduce suspensions and expulsions including pushing girls out of school, stop the flow of federal dollars to states and districts that support contracts with school-based law enforcement, promote restorative justice practices and more.
- **Assure the Department is equipped to enforce the Equity in IDEA Regulations**. The regulations went into effect in 2019 and state implementation assures students of color are not disproportionately impacted by decisions made by schools in the identification of children as eligible for special education, in placement decisions regarding where children receive their classroom instruction and in exclusionary discipline such as suspension, expulsion, referrals to law enforcement, seclusion and restraint.

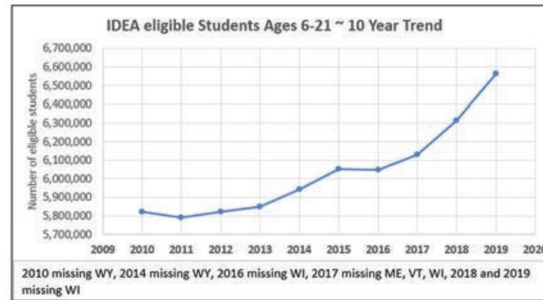
COPAA appreciates the opportunity to raise these issues and discuss a path forward. The pandemic has laid bare the inequities for many students in this country, students with disabilities and English Learners, students who live in poverty and shelters, students in foster care, Black and Brown students, rural students, Native America students for example. COPAA has and will

continue to work with partners in the disability, civil rights, education, and advocacy communities to support families, states, and schools as everyone works together to tackle the many challenges and embrace the unique opportunities resulting from the pandemic. We must ensure that all students impacted by COVID-19 because of disability, race, ethnicity, foster care status, homelessness and poverty are given resources to recover learning losses and ensure equity for all.

I appreciate the opportunity to speak to you today and look forward to your questions.

Addendum:

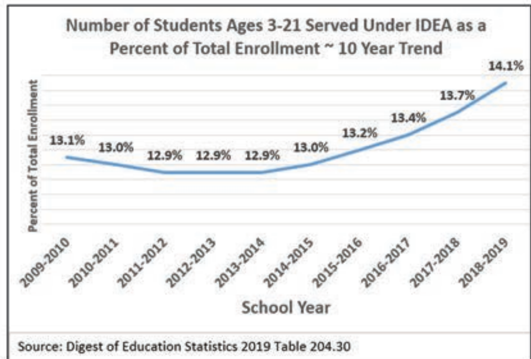
Data on students with disabilities served under the IDEA comes from the Annual Report To Congress required under Section 618 of the Act. These are 2019 data, released February 2021. Available at www2.ed.gov/programs/osepidea/618-data/state-level-data-files

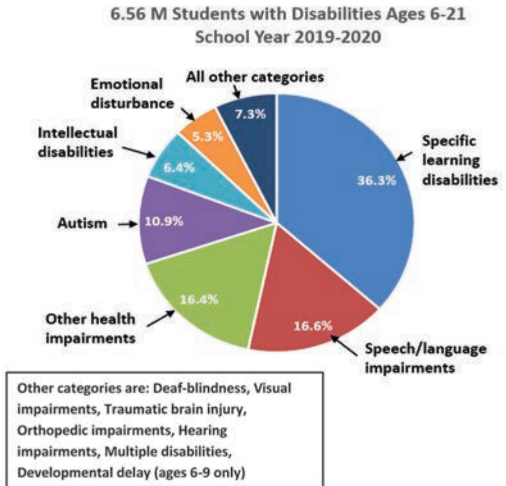


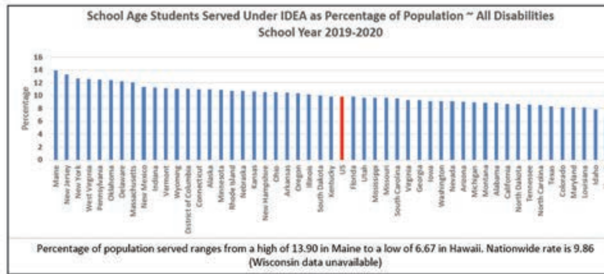
2010 missing WY, 2014 missing WY, 2016 missing WI, 2017 missing ME, VT, WI, 2018 and 2019 missing WI

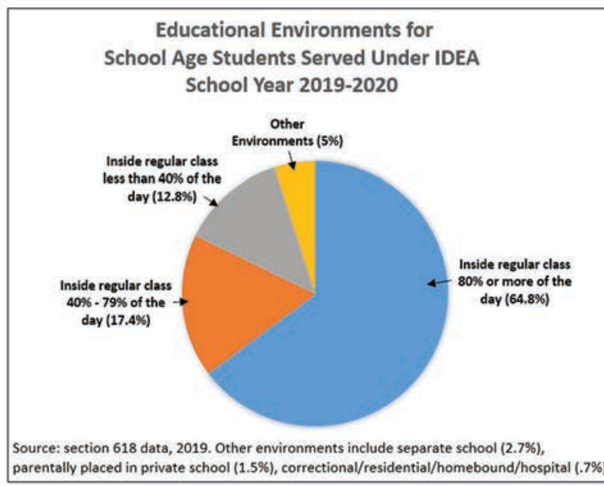
Number of Students Served Under IDEA Part B

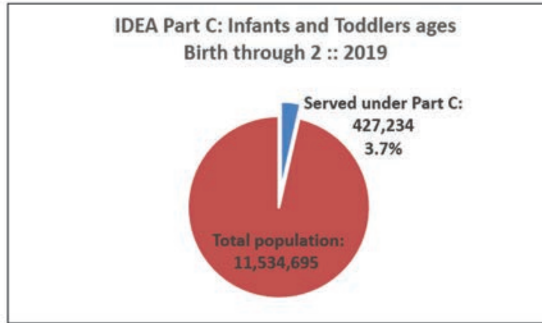
YEAR	AGES 3-5	AGES 6-21	TOTAL	% CHG
2015	763,685	6,050,725	6,816,425	1.7%
2016	759,801	6,048,882	6,808,683	-0.1%
2017	773,595	6,130,637	6,904,232	1.4%
2018	815,010	6,315,228	7,130,238	3.3%
2019	716,382	6,561,998	7,278,380	2.1%

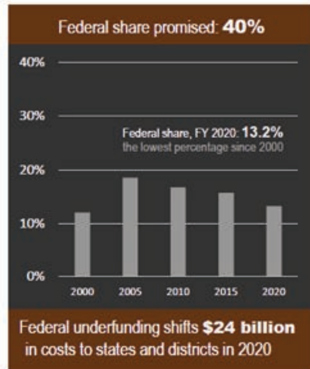

Number of Students Ages 3-21 Served Under IDEA as a Percent of Total Enrollment ~ 10 Year Trend
Percent of Total Enrollment
13.1%
13.0%
12.9%
12.9%
12.9%
13.0%
13.2%
13.4%
13.7%
14.1%
2009-2010
2010-2011
2011-2012
2012-2013
2013-2014
2014-2015
2015-2016
2016-2017
2017-2018
2018-2019
School Year
Source: Digest of Education Statistics 2019 Table 204.30

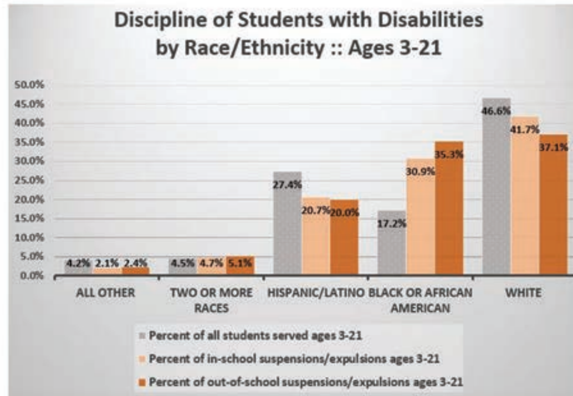

6.56 M Students with Disabilities Ages 6-21
School Year 2019-2020
All other categories
7.3%
Emotional disturbance
5.3%
Intellectual disabilities
6.4%
Autism
10.9%
Other health impairments
16.4%
Speech/language impairments
16.6%
Specific learning disabilities
36.3%
Other categories are: Deaf-blindness, Visual impairments, Traumatic brain injury, Orthopedic impairments, Hearing impairments, Multiple disabilities, Developmental delay (ages 6-9 only)


School Age Students Served Under IDEA as Percentage of Population ~ All Disabilities
School Year 2019-2020
Percentage
16
14
12
10
8
6
4
2
0
Maine
New Jersey
New York
West Virginia
Pennsylvania
Oklahoma
Delaware
Massachusetts
New Mexico
Indiana
Vermont
Wyoming
District of Columbia
Connecticut
Alaska
Minnesota
Rhode Island
Nebraska
Kansas
New Hampshire
Ohio
Arkansas
Oregon
Illinois
South Dakota
Kentucky
US
Florida
Utah
Mississippi
Missouri
South Carolina
Virginia
Georgia
Iowa
Washington
Nevada
Arizona
Michigan
Montana
Alabama
California
North Dakota
Tennessee
North Carolina
Texas
Colorado
Maryland
Louisiana
Idaho
Hawaii
Percentage of population served ranges from a high of 13.90 in Maine to a low of 6.67 in Hawaii. Nationwide rate is 9.86
(Wisconsin data unavailable)


Educational Environments for
School Age Students Served Under IDEA
School Year 2019-2020
Other
Environments (5%)
Inside regular class
less than 40% of the
day (12.8%)
Inside regular class
80% or more of the
day (64.8%)
Inside regular class
40% - 79% of the
day (17.4%)
Source: section 618 data, 2019. Other environments include separate school (2.7%),
parentally placed in private school (1.5%), correctional/residential/homebound/hospital (.7%)


IDEA Part C: Infants and Toddlers ages
Birth through 2 :: 2019
Served under Part C:
427,234
3.7%
Total population:
11,534,695


Federal share promised: 40%
40%
30%
Federal share, FY 2020: 13.2%
the lowest percentage since 2000
20%
10%
0%
2000
2005
2010
2015
2020
Federal underfunding shifts $24 billion
in costs to states and districts in 2020



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Chairman SABLAN. Thank you. Thank you very much Miss.

And finally, we'll get to hear from Mr. Alberto M. Carvalho. Please sir you have five minutes.

STATEMENT OF ALBERTO M. CARVALHO, SUPERINTENDENT OF SCHOOLS, MIAMI-DADE COUNTY PUBLIC SCHOOLS

Mr. CARVALHO. Thank you very much Chairman Sablan, Ranking Member Owens, and Members of the subcommittee. Thank you for the invitation to participate in this important hearing. A special salutation to my dearly beloved Congresswoman Wilson.

I am proud to say that Miami-Dade is one of the highest performing urban school systems in the Nation. We educate over

340,000 students each year, 93 percent of whom are minority and over 70 percent poor. However, our students regularly perform as well or better than their peers in nearly every academic measure and have achieved the graduation rate of over 93 percent during the pandemic.

The recent unprecedented Federal investments in education truly represent the potential to address long-term issues of academic equity in America. As our Nation moves to reopen schools, and I believe strongly that schools should and can open safely with the proper protocols in place, great care must be taken to address the needs of our most fragile children, children who are in poverty, children of color, children who are English language learners, and children with disabilities. We must move quickly, swiftly, and courageously to address the learning loss that students have experienced because of the disruptions to instruction created by this pandemic.

In our district, we have been transforming education and improving outcomes for all for well over a decade. And we did it by teaching and measuring what mattered and using the data to shine light into the dark gaps and places and drive improvement. We began with our youngest students creating high-quality, full day pre-K programs.

And then we looked to our secondary schools and found that opportunities were not always equal. So, we ensured that rigorous course offerings were available at every high and middle school, including AP courses, dual enrollment, Cambridge, and opportunities for acceleration for all.

We reinvigorated art, music and world languages, career technical education because all children have a right to an education that not only expands the mind, but also feeds the soul. We also implemented a tiered approach to providing the schools the supports they need, particularly those in greatest need, driving resources and wrap around services in a differentiated way to our most fragile and struggling schools and students.

And then finally, in 2012 we launched a digital initiative designed to integrate technology into all classrooms, to unlock the potential of digital content, empowering students and teachers as never before with individualized instruction. In essence, we eliminated the digital divide.

The result was a stunning improvement in graduation rates of over 30 percent, and an elimination of F rated schools in our district. All this work helped us prepare to rapidly respond to the unprecedented impact of COVID–19 in our school. On March 13, 2020, in-person schooling came to a halt, and we quickly pivoted to an online learning model.

We deployed 120,000 devices, more than 10,000 hotspots for connectivity, provided more than 30 professional development offerings to teachers to help support the transition to distance learning. Through constant communication and personal outreach to families, we achieved an impressive 93 percent average daily attendance rate during the school shutdown.

When we returned for the start of the 2021 school year, we briefly did what other districts across the country did. We opened 100 percent online, but with a plan, and an eye toward opening the

schoolhouses soon as it could be done safely. We assembled a task force of public health and medical experts, including U.S. Surgeon General Vivek Murthy.

We sought guidance and recommendations for safely returning to in-person school. Under the guidance and leadership provided by our own school board, all facilities were sanitized, ventilation systems were improved, personal protective equipment distributed to all employees.

Schools were reconfigured with single directional hallways, social distancing in classrooms following the World Health Organization of one meter which is three feet three inches. A mandatory mask policy was implemented, and medical personnel deployed to all schools.

We also arranged for the distribution of infrared thermometers to all families, developed an employee health screening app, and launched a public facing COVID–19 dashboard, successfully partnered with our various employee organizations, and agreed to protocols, workplace conditions, and accommodations.

And on October 5, 2020, Miami-Dade County schools returned to in-person instruction 5 days a week at all schools for all students who wanted to return. We currently have about 50 percent of our students physically attending schools while the balance has chosen to remain online.

This is in a district where we value choice. 74 percent of our students attend non-traditional programs. As I close, we have found that we have been able to navigate reopening safely, and that all schools have actually been safer than the community at large in terms of viral transmission.

Schools have always been and remain a safe haven for many who do not have a supportive home environment, who may be alone, who many be abused or neglected. We know there is work ahead to address the trauma and learning loss experienced by these children caught up in this crisis. The infusion of funding provided by the Federal Government is critical to meeting all these needs, but all involved must be diligent and responsible in the deployment of these dollars.

These timely Federal investments must be used in a manner that ensures improved academic achievement, operational efficiency, and fiscal responsibility.

[The prepared statement of Mr. Alberto M. Carvalho follows:]

PREPARED STATEMENT OF ALBERTO M. CARVALHO

Testimony

Written Statement of Alberto M. Carvalho
Superintendent of Schools, Miami-Dade County Public Schools
Before the Subcommittee on Early Childhood, Elementary, and Secondary Education
United States House of Representatives
"Lessons Learned: Charting the Path to Educational Equity Post-COVID-19."

Chairman Sablan, Ranking Member Owens, and Members of the Subcommittee, thank you for the invitation to participate in this hearing. My name is Alberto Carvalho and I have served as Superintendent of Schools for Miami-Dade County, Florida since 2008. I am proud to say that Miami-Dade is one of the highest performing urban school systems in the nation. We educate over 340,000 students each year. Our students are over 93 percent minority and over 70 percent poor. Our students also regularly perform as well, or better than their peers in nearly every academic measure and have achieved a graduation rate of over 93 percent.

I am honored to be here today to discuss education, equity, the lessons learned from the COVID-19 experience, and the investments needed to help the children of this nation on the road to academic recovery, acceleration, and success. This unprecedented federal investment in education represents the potential to address long-term issues of academic equity. As our nation moves to reopen schools, and I believe schools should open and can open safely, with proper protocols in place, great care must be taken to address the needs of our most fragile children, children who are in poverty, children of color, children who are English-language learners, and children with disabilities. We must move quickly to address the learning loss that students have experienced because of the disruptions to instruction created by this pandemic and their disproportionate impact on underserved students.

In Miami-Dade, we have been transforming education and improving outcomes for all students for well over a decade, and we did it by measuring what mattered and using the data to shine light into dark places and drive improvement. We began with our youngest students creating high-quality full-day pre-kindergarten programs and we then looked to our secondary schools and found that opportunities were not equal. So, we ensured that rigorous course offerings were available at every high school, including at least ten Advanced Placement courses, dual enrollment, Cambridge, and opportunities for acceleration. We reinvigorated art, music, and world languages, because all children have a right to an education that not only expands the mind, but also feeds the soul. We embarked on a project to re-design the middle school experience listening to the voices of the students who told us what needed to change. And we implemented a tiered approach to providing supports to schools that were most in need, driving resources and wrap-around services to our most fragile and struggling schools, often in our most underserved communities. Finally, in 2012 we began a process we termed digital convergence designed to integrate technology into all classrooms and to unlock the

potential of digital content empowering students as never before with individualized instruction. We paired this with deep and meaningful professional development for teachers and training for families and we put over 100,000 mobile devices in the hands of students. The result was an improvement in graduation rates of over 30 percent and an elimination of "F" rated schools in our District.

All this work helped to prepare Miami-Dade to rapidly respond to the unprecedented impact of COVID-19 on our schools. On March 13, 2020, in-person schooling came to a halt and we quickly pivoted to an online learning model. We deployed 119,000 devices, including more than 9,000 phones with Wi-Fi that were used as hotspots for connectivity and launched 30 professional development offerings for teachers to help support the transition to a 100 percent distance learning modality. Through constant communication, ongoing, often personal outreach to families we achieved an impressive 93 percent average daily attendance rate during the school shutdown. When we returned for the start of the 2020-2021 school year, we did what all other districts across the country did, we opened 100 percent on-line, but with a plan and an eye toward opening the schoolhouse as soon as it could be done safely.

We assembled a task force of public health and medical experts including former U.S. Surgeon General Vivek Murthy, infectious disease expert Dr. Aileen Marty, and others to seek guidance and recommendations for safely returning to in-person schooling. Under their guidance and direction and leadership provided by our elected school board, all facilities were sanitized, improvements were made to ventilation systems, personal protective equipment (PPE) was purchased and distributed to all employees, schools were reconfigured to provide for single directional hallways, social distancing in classrooms and common areas, a mandatory mask policy was implemented, and provision was made for a nurse or emergency medical personnel to be at each school. On October 5, 2020, Miami-Dade County Public Schools returned to in-person instruction 5-days a week for all students who wanted to return. We currently have about 60 percent of our students physically attending school while the balance has chosen to remain on-line.

We have found that we have been able to navigate reopening safely and that schools have actually been safer than the community at large in terms of COVID-19 transmission. We also believe that schools are a safer place for students that go beyond just the threat of COVID. Schools have always been and remain a safe haven for many who do not have a good home environment, who may be alone, who may be abused or neglected. These children, again often poor, often minority, have never been more in danger, more at-risk than they are right now without the safety of their schools to go to. Many students across the nation are "missing," right now. They have not been in school, have not attended on-line, and are essentially educationally unaccounted for. If not addressed, this could be our next national crisis.

Our District has employed a number of strategies to locate and re-connect these students in the educational process including daily phone calls to parents, home visits and parent conferences, social worker deployment, even school police-led visits. However, beyond

these traditional strategies, we have also collaborated with several organizations and agencies to help us locate and reach some of our most fragile students, after hours and on weekends. These partnerships include community-based organizations such as the Urban League, other public agencies such as the Miami-Dade Housing Authority, and a host of grass-roots entities that can help us access children living in migrant camps, subsidized housing, or who may be homeless, or part of the foster-care system.

There is work ahead to address the trauma and learning loss experienced by these children caught up in the COVID-19 crisis. The infusion of funding provided by the federal government is critical to meeting those needs but all involved must be diligent and responsible in the deployment of these dollars. We must collectively guard against wasteful and random spending. These taxpayer dollars must be used in a manner that ensures improved academic achievement, operational efficiency, and fiscal responsibility. States and school districts have a moral obligation to make investments which will open schools, protect health and safety, and address academic regression and acceleration. Such non-recurring investments should include considerations toward enhanced summer programming, extended day, week, or year, afterschool tutorials, instructional materials to support remediation, teacher professional development, and HVAC and other sanitization upgrades to maintain safe indoor air quality. Each of these is in direct response to COVID-19 impacts and are non-recurring beyond the period of necessary investment. Each of these investments must also be made with an eye toward equity, ensuring those in most need are the beneficiaries of the most support. Further, we would be sorely mistaken to ignore the fact that there were children in crisis prior to the COVID-19 crisis; it only got deeper and darker. The strategy to accelerate them to full potential cannot fall short by simply restoring their performance to what it was prior to the COVID crisis. We must not allow this to be looked upon as a time for opportunism, but as a time of opportunity. A time when we have an opportunity as a nation to provide solutions to long term resource disparity and strategically invest in academic equity.

Chairman SABLAN. Thank you. Thank you very much Mr. Carvalho. It just breaks my heart that I have to interrupt all our witnesses who have great ideas, so I need to do so. And so, we now turn to our Member questions.

Under Committee Rule 9(a), we will now question witnesses under the five-minute rule. So, I will be recognizing subcommittee Members in seniority order.

And again, to ensure that the Members' five-minute rule is adhered to, staff will be keeping track of time and the timer will sound when time has expired. Please be attentive to the time. Wrap up when your time is over and remute your microphone.

I will begin with myself, and as chairman, I will now recognize myself for five minutes.

On the CARES Act, the Coronavirus Aid, Relief Supplemental Corporations Act, and the American Rescue Plan, collectively appropriated nearly 200 billion dollars in grant aid to public schools across the country and allocated these funds by a Title I formula to ensure funds are targeted to where they are most needed.

I know here in my district far away in the Northern Mariana where it is said that if I dig straight down I would land up in Florida somewhere, but we were able to bring teachers where reduced hours, 32 hours a week, but we are able now to bring them back 40-hour weeks and start face to face instructions as well.

But Superintendent Carvalho, why is it important that these funds from this Coronavirus aid package, why is it important that these funds were allocated primarily to high poverty schools like my district for example?

Mr. CARVALHO. Well Mr. Chairman for the reasons that you addressed, obviously as believers in equitable practices we recognize that not every child, not every school is facing the same challenges. And with varying levels of challenge the funding needs to in a differentiated way be appropriated and delivered to directly support the needs of students and schools that face the greatest gaps.

And in our district, a district that is over 90 percent minority with a significant number of English language learners, where 11–12 percent of our children have one or more disability. We know where the need is. So, the distribution of funding following a Title I methodology is appropriate because it begins with a recognition where the greatest need is.

And in our district obviously we have earmarked and designated those dollars, and we have already spent 70 percent of the first ESSER allocation. We have designated and appropriated these dollars in what makes sense.

Look, we know that addressing the health and safety of our students and workforce, addressing academic acceleration, simultaneously providing social emotional support, all in unrecurring investments must be leaders in our consideration. Enhanced summer programming, extended day, week, or year, after school tutorial programs, and the improvements to the physical facilities which have deteriorated over time, particularly in the poorest communities.

So, the HVAC system replacements, the sanitization upgrades to maintain good indoor air quality, all of those were necessary investments, and those investments must begin with the children of America who were in crisis before the COVID–19 crisis began.

Chairman SABLAN. Thank you, Mr. Carvalho. Actually, you answered my second question as well, so I'm going to now turn to Ms. Almazan. Ms. Almazan in light of the challenges that students with disabilities face during the pandemic, it's enough that they face these challenges, even pre-pandemic.

In the additional funds provided by the American Recovery Rescue Plan, what are steps the schools can take now to ensure that all eligible students receive a free appropriate public education, even the need for appropriate COVID–19 precautions?

Ms. ALMAZAN. Thank you for the question, Chairman Sablan. The issue of free appropriate public education for students with disabilities remains the requirement and a commitment that all school districts and states have to comply with.

There have been no waivers during this time of the school closures. The question that's weighing heavily right now on many school districts and States is the idea of how we are going to make up for the learning loss that students suffered and the denial of a free appropriate public education because they did not get all of the services that are listed in their individualized education program, their IEP during that time.

And central to that, you know, we do believe is the issue of end of the year assessments. You know with the leadership of the Urban League, we agree that the end of year assessments, particularly in reading and math are going to inform the conversation of what kinds of compensatory education services students are going to need.

Compensatory education is an equitable remedy, not to get too much into the weeds, but it's an equitable remedy that is formed by courts to place a child with a disability in the position that they would have been in except for the denial, the educational loss, and not receiving all the services that they were supposed to receive, particularly during COVID–19.

Chairman SABLAN. OK. All right. I must cut you off, my time is up, but thank you for. I also once chaired the State Rehabilitation Advisory Council and have some idea of the IEP standard for students, particularly. My son is a teacher, so I do get first-hand experience, but thank you very much.

I will now yield to the Ranking Member of the Full Committee Dr. Foxx for five minutes of your question please, Dr. Foxx.

Ms. FOXX. Thank you, Chairman Sablan. I want to thank all of the witnesses for being with us today. You've presented some interesting things I'd like to comment on later if I can. Mrs. Dale thank you for your testimony and thank you for fighting for Lizzie and all the children in Oregon.

Your story is inspiring. One thing we've heard over and over again from teachers? unions and others who have fought against families like yours, to keep schools closed, is it simply isn't safe to reopen. Even the Biden Administration CDC has said that reopening most schools to most students is unsafe.

In your written testimony you made reference to sharing research on safe re-openings with State and local leaders. Do you believe that science indicates that schools can reopen safely? And how did those States and local leaders respond to that science?

Mrs. DALE. Thank you for your question, Dr. Foxx. I over the last, since September we've seen studies and the groups that I've been a part of have worked really hard to review the different information from the CDC, from the WHO, from American Academy of Pediatrics, in helping to inform, you know, whether or not it's safe to return.

A lot of—Emily Oster and a study out of North Carolina, several studies came out to indicate that you know there was a safe way to return to school, and we know that there's a safe way to do that by wearing masks, and social distancing. So those are the kinds of

things that we have written to our local lawmakers and to decision-makers here, like the Oregon Department of Education to say this is how other schools are safely reopening, and can we do this here in Oregon?

But their response generally was we've got to wait for case rates to come down, or we need to wait for the vaccine, and it felt like a lot of those goalposts sort of kept moving, and kept moving, and kept changing even though we were able to see schools in other countries and schools in other locations open.

Ms. FOXX. Yes, and it's interesting to me that you're in one of the most political states in the country, and all these people profess that they care about children. Everybody on this panel, all the witnesses care about children. They've been given billions of dollars, and yet they won't open the schools.

It's the worst hypocrisy I've ever seen. You also said in your testimony you plan to have Lizzie repeat third grade. And I heard what you said. She has to make a whole new set of friends. That's difficult for any child, any child. Can you tell us more about what led you to that decision, and if you think that decision would have been necessary if the schools had reopened when it was safe to do so?

Mrs. DALE. We definitely wouldn't be having this conversation if the schools had reopened in September, and Lizzie had been able to join her cohort of friends that she has built actually since pre-kindergarten.

And the reason that we're having to make that decision now is that you know the online platform for schools is really a one size fits all. And I think some students have you know we've heard stories here in Oregon and elsewhere that some students have fared OK in that platform.

But many haven't and you know, over 80 percent of the kids here want to go back to in-person learning, and their families want to get those kids back to in-person learning. For Lizzie, I spent mornings with my arms literally wrapped around her stomach trying to keep her in front of a screen, and there was a teacher, an aide, and a learning specialist on the other side of the screen trying to help Lizzie with counting, and with writing and reading.

It isn't just it was a platform that was impossible. And so, we could either choose to spend our mornings in tears for two and a half hours, trying to learn over that platform, you know, with a child who didn't understand why her teacher had her muted, or why the other kids wouldn't wave to her and say hello, or we could—we just didn't have a choice.

I mean we couldn't just keep her staying you know involved and engaged in that platform. And I think that was for us what felt very overlooked in the guidance that was released about learning online is that children with cognitive disabilities, they're motivated by their peers.

They're assisted by their peers in learning. And when that isn't there online, their learning just doesn't happen. And so, she has 7 months of no general education.

Ms. FOXX. You have a great civil rights case on your hands based on the legislation of IDEA, based on the comments one of the other witnesses said.

Chairman SABLAN. Thank you, thank you Dr. Foxx.

Ms. FOXX. Thank you, Chairman Sablan, thank you so much Mrs. Dale for being such a great model.

Chairman SABLAN. Right, Ms. Dale thank you. Some of your statements are personal experiences that are just incredible. I hope we are going to eventually open up so I could come and visit my grand and my great grandkids also, so thank you.

Next, I'd like to recognize Mr. Yarmuth. Mr. Yarmuth you have five minutes sir.

Mr. YARMUTH. Well, thank you very much Mr. Chairman, and thanks to all the witnesses for their contributions today. I want to start by referencing something Mr. Owens said in his opening statement, and Mr. Owens I wanted to let you know that I was a New York Jets fan when you were playing for them.

I was also a registered Republican at the time, so I'm not sure what that says about either the Jets or the party. But I'm really concerned about this notion that the Democrats are somehow unconcerned about IDEA, and the students that are served through that program.

Both President Biden, and I know Speaker Pelosi and many others have said show me your budget and I'll understand your values. And I think that's very true. And in the American rescue plan we committed 3 billion dollars to IDEA, along with 130 billion dollars for education overall, much of which can be used to support students with disabilities as well.

So, I think it's kind of disingenuous to question Democrat's commitment to IDEA when every Republican voted against that proposal, and not only voted against it, but I don't remember I was present for most of the debates, never one time saying that any portion of the American Rescue Plan was worth supporting.

So, I'm certainly, I think we always ought to oversee in Congress, any of the programs that we mandate. So, I'm not necessarily saying we shouldn't again take care that our money is being spent wisely and effectively, but again the hypocrisy here is pretty astounding.

And I also have to take issue with this weaponization of the idea of opening the schools. And I've heard it day after day after day for the last couple of months. The Republicans want States and localities to have control over things when it serves their political purposes, but when it doesn't, then all of a sudden, they want the government to mandate what the opened.

I was in a conversation last week with a superintendent of the Fleming County Kentucky School System. Fleming County, Kentucky is in the eastern part of the State, not in my district. It voted for Donald Trump 78 to 21, so it's certainly not a blue area. Their school system has 2,200 students. The superintendent, they opened school partially, I shouldn't say partially, on a voluntary basis last September, so before there was any CDC guidance on what was safe, and what wasn't safe.

They're still open now. About half of their students systemwide are actually attending in person. Those parents, those families made their decisions which I always thought was what Republicans thought was the appropriate thing to do.

This is a very complicated situation. We're all very much in uncharted territory and have been for a year now. So, I really resent all of this politicization that the notion that once again now because Democrats are in charge, we have to make everybody open schools.

When even when Donald Trump was in charge, that we ought to open all schools. I don't think that's the way this country works, and our families work. I do have one question I want to ask of Superintendent Carvalho. I don't know how much your school system is going to get, but I know based on what my school system is going to get, it's a lot of money.

And one of the things that we were criticized for throughout this debate was a very small percentage of this money is going to be spent this year, this year meaning over the next 6 months. As you contemplate using the funding that we provided to the American Rescue Plan to the Miami-Dade schools, where do you perceive the need being today versus next year or the year after, and things that you may do with that money during that period of time.

Chairman SABLAN. I have 39 seconds for that Mr. Carvalho.

Mr. CARVALHO. I'll be very quick. Thank you very much for the question. Certainly look, we're going to bucket into three areas. No. 1, continue to improve the environment of schools, sanitization, additional equipment, indoor quality improvements, capital projects.

Second, acceleration strategies to ensure that those who fell behind are able to catch up, not only to where they were prior to the crisis, but actually to their place, where they should be in accordance with their chronological age and grade level. This is not only about taking them to where they were prior to the COVID crisis.

And that's going to require massive amounts of investment. And before and after school programming, year around schooling, summer schooling, before and after programming, individual tutorial programs and individualized digital content to support them pedagogically as well as socially and emotionally. That's where the brunt of the investment is going to go.

Mr. YARMUTH. So, by definition that has to be done over time.

Mr. CARVALHO. It will take some time. This is not going to necessarily be a sprint, but at the same time the more we wait, the more children will fall behind so it will be very swift based on the plans that we already have in place.

Chairman SABLAN. Thank you. Thank you. And if it weren't for Mr. Yarmuth if it wasn't for your work in the American Rescue Plan, my schools would not be open for face-to-face instructions, and my teachers will still be going on 32 hours a week paid, so thank you, thank you. At this time, I recognize the Ranking Member of the subcommittee Mr. Owens. I had no idea you were a professional football player.

Mr. OWENS. Thank you, thank you so much and I'll say for those still rooting for the Jets I tip my hat and I'm sorry to hear about the misery they were going through the last few years. Anyway, that being said, let me just say this. You know we just put another 130 billion dollars on this last bill. We already had money in there before, to make sure that our schools opened.

We haven't done nothing to spend. So, I think the question comes down to look at states like Utah. Utah, we opened up pretty quick-

ly. We gave the power to the people to decide how we wanted to make sure that we can—businesses opened up, schools open. So, one of the leaders in the country as far as our economy coming back.

But I'm talking with kids in their schools every single day. And the problem is this. Across our country parents are the same. Our children are the same. We want to make sure that our kids are moving forward. So yes, you're right. We have to deal with the fact that there are different ways of approaching this.

It appears that the democratic states are the ones that are shutting things down. We have issues like this where our kids are literally, and those that are hurt the most are those at risk, those that are poor, and those are the ones that we are now fighting for. There should never be a process in which across our country we have such a disparity in terms of how we're dealing with something that is common between all of us.

So that being said, I want to say first of all to Mrs. Dale, thank you so much. There are no stronger advocates for children than their parents, and you truly are showing America what that looks like. We don't sit back and wait for others. We roll up our sleeves and go to work.

And thank you so much. You're old school parents, and there are a lot of parents across this country trying to figure out how they can do the same, so you're a great example for us. Mrs. Dale, again, thanks for sharing your story. Ranking Member Foxx asked what was learned about risk of reopening schools.

We know from the science that reopening schools is safe. We also know that it's not 100 percent risk free. Nothing in life is. Why would you say that whatever risks exists in sending your daughter back to school was with it, or do you think that it was well worth it to have to take some risk to make that happen?

Mrs. DALE. Yes. Thank you for the question Ranking Member. It's a true honor you know to advocate for my daughter in this manner and in this light. Because I feel like you know she doesn't have a voice always. And the risks, there's always a tradeoff. There's always some costs and benefits to the things that we do. My daughter with Downs Syndrome, I think you might know this.

If you have a cognitive disability, or developmental disability, you're generally in the 1-A group for example. No side effects, and if you get COVID–19 it does hit harder and it is more severe. But you know, the other side of that is having a disability, whether it's physical, whether it's a cognitive disability, it can be very isolating, it can be very lonely.

And for us the tradeoff was you know we saw her here at home very lonely, very isolated, not learning, not able to get onto a Google classroom and see friends and see peers each day. And that's just no way to live. There's no way to live a day or a year, or a week, or anything like that.

And so, what we really did as we went to work with the school, and said you know we know that masking, and we know that distancing works, and can you work with us to at least give her a couple of hours in person education? We can do some worksheets. I mean we worked really hard with the school to find some way of getting those doors back open.

In fact, she was the first person in her school district to return to school. And the tradeoff for us was just that living as isolated and lonely as that was, was just never going to be sustainable for our daughter and for our family. It's very sad, very sad.

Mr. OWENS. Being raised by teachers myself I understand that. And let me say this. Your concerns you have, what you're going through has absolutely nothing to do with Medicare for all, defunding the police, wealth, and meeting your tax, 500 billion dollars in school State loss nation-wide, housing security and a charter school moratorium.

And these are the things that would be demanded by our teachers? union so that young people, children like yours can actually go back to school. It should never, ever, come to that point, but we've been held hostage. For these types of things, it has nothing to do with our kids growing up and expressing the American dream and their future.

So, I want to thank you for that. I won't have time for another question, so I'm going to yield back, but thank you for everything you're doing. Really, really proud of you on this issue.

Mrs. DALE. Thank you for having me.

Chairman SABLAN. Yes, thank you. Thank you, Mr. Owens. So next I'd like to recognize Ms. Wilson. Ms. Wilson you have five minutes please.

Ms. WILSON. Thank you, Mr. Chair.

Chairman SABLAN. All right Federica.

Ms. WILSON. I just have to say to everyone, just be aware that we are in the middle of a pandemic. This is a health emergency that no one could ever, ever predict. And the one group of people who kept our children afloat were our teachers, because all schools had to shut down. And I've seen so many parents who have said to me now I respect the job of a teacher, and I will never again vote or try to advocate for anything but a raise for teachers, because they kept the boat afloat.

So, this whole pandemic has caused us to be able to peel back the layers I would say, on an onion, and we see so much disparities as we peel back the onion. I had one little boy say to me, I said I need you to take a picture for the newspaper, but I want you to sit at a desk. Sit at a table, in a chair, with a blank wall.

He said, "Ms. Wilson, we don't have a table." I said you don't have a table in the whole house. Where do you eat? He said, "We eat at the kitchen counter in shifts." So, I want to say that the money that was sent to the school districts, not only do we need to worry about what our superintendents are doing to make our schools safe, which is what they have done.

My school superintendent has done it. My neighboring schools superintendents have done it. Mr. Scott and I held briefings with teachers in Miami-Dade, Broward, and Alabama. And the disparities that we saw between those school districts. And Broward and Dade I can say I'm proud, Alabama.

So not only do we need—I want school districts across the Nation, including the two that I represent, to commit to using the Title I formulated money to give every Title I children a computer, a desk, and a Chair to take home in their homes because homework will not disappear. And broadband access will not disappear.

And just having a quiet place to do your homework and everything else is so important, and I'm sure our superintendent and our parents and everyone else on this call agrees.

I just want to say tutoring—and we have all agreed, and our Superintendent Carvalho has said that summer school, we have the summer slide, we have the COVID slide, the COVID–19 slide, and now the children just call it the 19. So that slide we have to close that achievement gap back, has exacerbated what we have seen for generations.

And all of the money that Democrats put in a bill that was not supported by one Republican, and my school district got one billion dollars. We expect to see a huge change and everyone, not only teachers and school districts, but the community has to work together to pull these children up.

I want to say that I heard Mr. Morial, how can these short-term resources be used to create the long-term systemic changes necessary to provide all students with equitable access to an excellent education. You talked about it in your remarks.

Mr. MORIAL. Yes, thank you very much. We've got to understand that Congress is to be commended for appropriating the additional money, but one of the equity issues that American schools face has been a severe resource gap, differential investments in schools with inner school district differential investments within schools from county to county, or district to district in a given State.

I think that each school district and the Miami Superintendent outlined his thought process, has to intelligently employ this additional money around proven strategies—evidence-based strategies. It may be reading coaches. It may be accelerated learning in the summertime.

It may be to provide every child with a Chromebook so that they can go home and even if they're in class, they're going to be doing homework, to provide those students with the resources that they need to be able to play catchup. We're going to be playing catchup.

What I do hope is that this investment would demonstrate why closing the resource gap amongst American public schools has to be the work not only of the Congress, but of the States and local schools districts because that's one of the fundamental issues that we face.

Chairman SABLAN. Thank you very much. Ms. Wilson thank you very much. There was just an education summit just yesterday I think, and there is no disagreement among everyone that we need to get schools open, but there was also no disagreement among all the participants that we have to do it in a safe manner, that we're still reaching out in the dark in this pandemic, and it's dangerous because somebody could infect somebody, and you know we're talking here about not yourself, but we're talking about lives.

And so, we need to do this in a safe manner, and there's no disagreement just like we all want to go back into the committee room, we all want our children in schools, our students back to school. Some may do it faster, more quicker, some may take a little bit of time. We will get there, it takes work. And of course, it takes the resources that we just appropriated that nobody on the other side of the aisle supported but thank you.

I now will recognize Mr. Grothman, please sir you have five minutes sir.

Mr. GROTHMAN. OK. I want to get through three quick questions here. The first question I am asking, in my area, there are several private schools, maybe Catholic schools, Christian schools, Lutheran schools what have you. They almost all seem to be open, and at least some of the larger public schools are closed.

Can anybody give me, any one of the four of you give me a reason as to why it seems that the private schools seem to stay open in disproportion to the public schools closed? Does anybody want to take a shot at that?

Mr. CARVALHO. To the Chairman, I can tell as superintendent of the fourth largest school system in America we have had 100 percent of our schools open on the basis of parental choice, since early October.

I can tell you that about 50 percent of the students in Miami-Dade attend school in a physical way. I can tell you also that we were very diligent in establishing all the protocols and the mitigating strategies, and the policies established by the board for the safe return of the students, and we were also diligent in the appropriate conversations with labor organizations for the workforce.

Mr. GROTHMAN. I know you were. The question is why were others not open?

Mr. CARVALHO. Well, I can tell you that we live in a time of high positivity rate in Miami-Dade. I think our instructional continuity plan and level of preparedness put us in a position of following science. And the science does put us in a position of being able to open schools.

Mrs. DALE. I can comment too as Congressman Grothman, I had to switch two of my children to private schools, so my daughter Lizzie with the disability remains in public school, and she's getting the fewest instructional hours out of any of my three children being in public school.

And my two children who have moved over to private school are now in full-time, in-person, and the challenge that we're facing right now with my daughter Lizzie receiving services is that there's in the contract for the teachers to come back to work, is a work from home condition, that has been—they've been unable to renegotiate.

So, I think that's been one of the biggest problems in our areas.

Mr. GROTHMAN. Thank you, thank you. But it kind of surprised me because I think the public schools usually have more money, so it's a little bit surprising. Next question I have, I was looking at some of the money going out to Milwaukee and our poorer district, Milwaukee is getting funding, 63 percent of their normal budget is coming in from the feds, whereas it looks like your average school district, Wisconsin 10–15 percent, not even as much.

I realize there's a feeling out there that we have to give more money to the school districts with more kids in poverty. And of course, Milwaukee and Wisconsin already start by spending more money in the average district because, you know, we drain money across the more middle-class districts to fund Milwaukee.

But 63 percent compared to like 7 percent, 10 percent with the other schools, does that sound to you is a little excessive of a dif-

ference? Are we going overboard in flooding money at the more Title I districts?

Mr. MORIAL. Let me ask. No, not at all because the money is needed because of systemic inequities. When you talk about what do need should be the guide. And many of our urban school districts have been underfunded, and because they are, in urban areas

Mr. GROTHMAN. I need to cut you off.

Mr. MORIAL. Please don't cut me off. Please don't cut me off. You asked me a question. I want to answer the question. And so, my point is, is that it's more than justified. The Title I formula was established in the 1960's and the additional funding that Congress appropriated following the Title I formula which is based on need.

Mr. GROTHMAN. OK thank you. Final question. I noticed when you talk about your school districts, not just you, but everybody. We seem to talk about race, or we talk about poverty, and I sometimes think family structure maybe is more important than those. Can you tell me why the education establishment lays out what type of students we have?

We focus on people's ancestry you know, eight or nine generations ago, or we focus on money, but we don't focus around family structure. Would it be helpful if we also went to those statistics? Maybe I'll ask the guy from Miami-Dade that question.

Mr. CARVALHO. Thank you, the guy from Miami-Dade is ready. Sir, I think that No. 1 a lot of the gaps, academic gaps that we deal with are proceeded by all sorts of social gaps, whether it's home insecurity, family instability, a lack of adequate access to food or home.

In Miami-Dade, I can tell you that we take into account all the elements that influence the child. That is why we developed a parent academy, which is a college to support parents to become an echo of education for their children.

We intensified at parent academy during the pandemic, to really assist parents in providing ideal educational environments in their homes during the school closure, ensuring that the parents had better knowledge of the devices and the digital content that their students were utilizing.

So, it's not an either/or, it's a recognition of all of the social gaps, the financial gaps that children fall into before they arrive at the schoolhouse.

Mr. GROTHMAN. So, there's statistics even, you didn't collect the other statistics?

Mr. CARVALHO. I'm sorry?

Mr. GROTHMAN. To see how well you're doing. Do you collect the statistics by family background?

Mr. CARVALHO. Certainly, for me it's actually more important, the statistics that others collect. So, I wear two hats. I'm superintendent of Miami-Dade, but I'm also a Member of the National Assessment of Educational Progress Board, and Miami-Dade's 4th graders, despite the level of poverty, despite the English language limitation, and despite the 11 percent that have one or more disability, according to the NAPE, the last administration of NAEP in reading and mathematics, NAEP TUDA, they are No. 1 in the country in 4th grade reading and mathematics.

So, schools with the appropriate supports through the diligence of leadership, data-driven strategies, and the incredible powerful work of teachers and visionary policy on the part of support, can in fact overcome some of those issues.

Chairman SABLAN. I love the back and forth, but I must interject and recognize Mr. DeSaulnier next. Mr. DeSaulnier you have five minutes sir.

Mr. DESAULNIER. Thank you, Mr. Chairman. Thank you for holding this hearing. Just a comment from the previous questions from the gentlemen from Wisconsin. In relation to my district here in the San Francisco Bay area, that used to be the former Chair of this committee, Congressman Miller, was in the Congress for 40 years.

Our district has some of the wealthiest districts, my district now in the San Francisco Bay area in California. And we have some of the poorest and some in between. And we've been working along with the current superintendent of public instruction in California and the previous one, both of whom came from this district, to try to deal with this disparity.

We worked very closely with Governor Brown when he did the local control formula that helped California move even more money under Title I, well consistent with Title I. So, the disparity of the family structure, we know the history across this country. And you've talked about it. And it's just frustrating to hear these conversations. We've been studying this for decades.

The pressure in my district on a single woman of color who's got kids prior to COVID, and the inequality in this country was already astronomical. So, there's the paleness that's not true in others, sort of shocking that we'd even talk about this now.

We know where the challenge is, and we know the benefit not just for that community that historically has been treated so poorly by this country in my view, but also the benefit to all of us if we invest in that community, and I'm very proud of that legislation that Congressman Thompson and I did on family engagement centers a couple sessions ago. So sorry for that editorial comment.

My question for the panel is we've got all of this that I just alluded to prior to COVID, and COVID of course had a disproportionate impact on these districts and the students. It strikes me that there's both a challenge and an opportunity. We already knew that single parent households in poor communities, and communities of color were very heavily challenged to get the kids to school, to get them in school, to get them support after school.

And all those wrap around services would have worked so hard for. And then you got COVID where Chairman Scott has talked about. Forty percent of the schools in this country don't have heating and air conditioning, so we've got to go back in and provide that infrastructure for the future of public health.

So, in that context maybe you could respond starting with the Superintendent of Miami. The challenges and opportunities of coming out of COVID, particularly for this affected community.

Mr. CARVALHO. Thank you so much for the question. I'll try to be very brief. You know I think you touched on a very important point, let me reflect on the previous questions as well. Look, I think the strategy to accelerate students, particularly students who fall

into those gaps that you described, to accelerate them to their full potential, we cannot simply restore their performance to what it was prior to the COVID crisis.

And we simultaneously cannot allow these investments which are so sorely needed. We cannot allow this to be looked upon as a time for opportunism, it's rather a time of opportunity. A time when we have an opportunity to as a nation provide solutions to long-term resource disparity and strategically invest in academic equity.

And for me, whether we're talking about the black, Latino communities, impoverished communities, students with disabilities, for me that requires strategic investment resources that follows yes, follows the condition of the child in the school. Otherwise, we will never reach equal results because the process of equity requires differentiated resource investment, depending on the condition.

Second, it requires family engagement, support for the communities. It requires additional time on task by the best teachers around us. That means summer sessions, spring break, we're going on spring break this coming week. There will be about 80 schools in Miami that will be holding session.

For some students social emotional support, pedagogical educational support throughout the summer, but also with arts and music access, so that they benefit from the experience. And last, you know, and this is still an issue across the country many places, the digital divide still keeps a lot of students, a lot of communities, a lot of parents to education that is bell to bell.

After the last bell there is a total level of disengagement. That is why we rushed to address the issue of eliminating the digital deserts for that condition to be eliminated, and our students can continue to learn after the last bell. And if the computer is home with connectivity, we can simultaneously address the needs—the long-term needs of parents.

Mr. DESAULNIER. Just Mr. Chairman one last thought.

Chairman SABLAN. Thank you, OK, make it quick.

Mr. DESAULNIER. OK. One of the wealthiest school districts in my district, a third of their funding comes from the foundation, so the parents. So just this dichotomy I want to re-emphasize. Sorry to take so long Mr. Chairman. And nothing against the parents who have money contributing, but it demonstrates to me the challenge here in the dichotomy. Thank you, Mr. Chairman.

Chairman SABLAN. Yes, thank you. Mr. Carvalho if you ever have a need for a job as school commissioner in my district, no wonder Ms. Wilson is so proud of you sir. Thank you. Now I'd like to recognize Mr. Allen please for five minutes, Mr. Allen.

Mr. ALLEN. Thank you Chairman and thank you to all of those with us today. Can you hear me?

Chairman SABLAN. Yes sir, yes sir.

Mr. ALLEN. OK great.

Chairman SABLAN. We're just happy to see you again.

Mr. ALLEN. Yes, happy to see you. Evidently, I got booted out of the Ranking Member on this committee, but somehow I got on another one, so I miss you. But K through 12 is very special to my heart, and it's been a difficult year.

Obviously, I pushed my district to reopen schools as well as pretty much the entire State of Georgia except maybe metro Atlanta, but we are open. I have 14 grandchildren and we have a special needs grandchild. She cannot walk. She cannot talk. She cannot sit up and she cannot feed herself and she's 4 years old.

But when I'm around she walks, come to me and she sits in my lap and hugs my neck and just smiles at me. She is absolutely the most precious grandchild that God could have given me. And I'm just tickled to death. And she's been in school off and on. They've had kids with COVID, and she's had to come home, and then she's had to go back.

And one time she was actually apparently very close to one of the children that had COVID or an adult, and I guess it was maybe one of the staff, and she's never had it. So, I guess she's asymptomatic. I don't know. But it's just amazing. She's an amazing child.

But obviously, it's been difficult. And I want to say thank you to all of our educators who I mean you know there were two ways to go with this thing. We could either surrender, or we could fight. And you know at least the educators that I know very closely and what I've heard here as testimony today, you all are fighting. You're in harm's way. You're doing it for the kids.

We have people in the food business that do that. People in the healthcare business have done that. A lot of Americans have stepped up and kept this thing going through unprecedented time. Ms. Dale your story is amazing. And you described that you had covered your concerns, but you heard from other parents, especially those having children with needs, some like your daughter's.

Can you describe why you went public with that?

Mrs. DALE. Yes. I don't think I had a choice. I think that my daughter Lizzie, she wasn't going to learn at all this year unless we did something, unless we said something to the district, and to our State leaders that what was going on.

And I think that as you might know, you know, during COVID, all of us parents felt like what was going on in our homes was so private and none of us wanted to fail, and so none of us said anything until sort of looking around and saying wait, that's happening with you too?

Or you're having a hard time too? And so as soon as one person spoke up and said this was difficult for me it enabled a lot of other parents to speak up and say I'm having a really hard time with my kids too, and it's kind of embarrassing. It's a feeling of failure, but then other families trying to get the resources for their kids, we get specially designed instruction for my daughter, and that wasn't something that was being offered.

And so, while some families like ours chose to really fight and come to the table and figure out a way to get some of those services delivered, other families had to give up. And a lot of families had to unenroll from school because those services weren't being offered, or delivered, or provided to them.

Mr. ALLEN. Yes well, let me tell you. This is our founders gave us a grassroots principle. They gave Americans the opportunity in the First Amendment to voice our concerns when we see them, and this country will always be a grassroots country. Special interest

tries to rule, but I'm telling you the people in the grassroots efforts are what gets things done.

Thank you for bringing attention to this, and I know it takes a lot of courage to do that, because you probably got criticized along the way.

Mrs. DALE. Um-hmm, in fact I was on a couple of radio stations trying to share our story, and I'll never forget one parent posting this so publicly saying, "Oh that mom just wants her most difficult child out of the house."

Mr. ALLEN. Right.

Mrs. DALE. And I think that was the moment that I thought no, actually I just want my children to get an education. It was harder for us to get an education.

Mr. ALLEN. Yes. It's been tough and thank you. Chairman I yield back.

Chairman SABLAN. Thank you. Thank you, Mr. Allen. Let me see. All right. Let me go on, Mr. Morelle?

Mr. MORELLE. Thank you very much Mr. Chairman.

Chairman SABLAN. No thank you for your patience, sir.

Mr. MORELLE. Yes, well thank you. This is a very, very important hearing, and I think there's no question that all of us I think recognize the importance of having children physically back in school when we can, and I think that's what we're all working very hard to do, recognizing however, that we want to do it appropriately.

I had sort of two different questions that occurred to me during this conversation, and I appreciate very much the witnesses being here and lending their expertise. The first is around the question of children with different abilities. And we've talked a fair amount as Ms. Dale has pointed out, and I thank her very much for sharing her story, that children with different abilities are more vulnerable to the virus, maybe among the most hesitant to take the risk of returning to school.

But I wonder if the educators could talk about measures they have taken in the schools that are open to keep students with disabilities from falling behind. Well, I guess first of all, for those who are unable to be in the classroom, what steps have you taken to ensure that children with different abilities can still get a quality education?

Could we have some comments from the superintendent in Miami-Dade for those students who weren't physically in the classroom what they've done, and what their experience has been?

Mr. CARVALHO. Certainly. Thank you very much for the question, for the Chair. No. 1, about 52 percent students with special abilities are currently enrolled physically in our schools, so they're attending physical classroom. Over the past two grading periods, the first two quarters, we identified additional students that we believed should be in the classroom rather than at home, and we have had conversations with their parents.

Despite their choice of modality, we felt it would be in the best interest of the child to actually return to school for a more direct intervention for them. But for those, specific to your question, for those whose parents decided to keep them at home, we taken a number of actions.

No. 1 we ensured that all these students with disabilities had access to curriculum through the provision of assistive technology that goes above and beyond what's typically provided for students, adaptive accommodations specialized supplementally curricular resources.

We developed a distance learning implementation plan for each student with a disability describing how their IEP would be implemented during distance learning. We provided ongoing professional development for teachers and para-professionals for this new adaptation, and as appropriate the necessary therapies entitled to this child via their IEP.

We conducted the traditional IEP meetings with cycle educational evaluations continued virtually throughout the closure, so that students who required specialized services and supports could be not only identified, but actually receive these supports.

Last, we supported the families. We established hotlines in addition to webinars for parents to be aware of their rights, and how to best maximize online resources and the adaptive technologies.

But again, I'd like to close by saying there is for a child with disability, who requires hands-on intervention, a para-professional, one on one. There is no substitute for the experience that our teachers provide in school. That is why we keep urging those parents to actually return children to the schoolhouse.

Mr. MORELLE. Well, look I thank you very much. And it occurs to me Mr. Chair, perhaps we ought to be thinking about best practices and protocols for those instances where children with disabilities are not able to be physically in the classroom. And I have just a minute left.

But one of the other things that I'm very interested in is the pandemic has given us certain learnings, one around telehealth and telemedicine and the greater use of technology. Obviously, distance learning has had its challenges in terms of the deployment of broadband, both in rural communities, urban communities, so I'm troubled by that and how we need to work together to be able to make sure that deployment is greater in the future.

Not only for increasing the opportunities for children in pandemics, but I think even for enrichment opportunities where additional online content might be available, but it's just not simply available to certain children in certain communities. And I wondered if people could just—and I apologize, because I'm down to 20 seconds, so it's going to be really short answers. The feds will continue to add resources.

We have done that in December in our last American Rescue Plan. Are there ways for communities to sustain it with what will be limited Federal resource in the future and how much of a priority will you put in the local districts. And I'd ask anyone, perhaps Mr. Morial if you might have a comment?

Chairman SABLAN. Out of time. Maybe someone, it's a good question. Maybe someone will give you time.

Mr. MORELLE. I yield back Mr. Chair thank you.

Chairman SABLAN. Thank you. I now recognize Mrs. Miller of Illinois. Mrs. Miller going once, going twice. All right. Mr. Cawthorn sir, you have five minutes. Mr. Cawthorn going once, going twice. I know he's online, but I guess he stepped away. Let's see Mr. Yes,

Mr. Keller. I apologize. Mr. Keller you have been very patient. Sir you have five minutes.

Mr. KELLER. Thank you, chairman. Republicans and Democrats should be united in working to safely reopen our schools. As we've witnessed, I brought to the attention several times before the committee. Most recently during remote hearings in the U.S. Congress, over at the capitol, and we cannot get the technology right with all the resources we have right at our disposal.

And the staff quite frankly, how can we expect our students to participate in virtual learning? Virtual learning has played an important part while we reopen our schools. But not just in parts of north central and northeastern Pennsylvania, and in other rural areas around our country, but also in urban areas all across the United States.

Virtual learning is not always as reliable as we witnessed with the issues we've seen, even in the capitol city Washington D.C. Every student learns differently, and we cannot rob an entire generation of students of the choice that they need to pursue an education.

For instance, the CDC has warned that the absence of in-person education options may disadvantage certain students with disabilities. The continually changing nature of COVID–19 guidelines makes it that much more challenging for school districts, school administrators, schools, teachers, parents, and students.

The evidence is clear. Students should be allowed back in the classroom and be permitted to attend school in a safe manner. Mrs. Dale, I thank you for being here today, and for sharing your experience and your story. I can only imagine what it has been like having school-aged children during this pandemic and seeing them lose out on critical in-person learning.

I wish nothing but the best for Lizzie and the best of your family, and everybody as we continue to reopen our schools. Your story underscores the importance of having choices for students during the current pandemic and going forward. How would your experience have been different if there had been more flexibility for in-person learning during these tight reopening restrictions like in Oswego, Oregon?

Mrs. DALE. Thank you. Thanks for the question, Congressman Keller. You know I have some choices for my other two children, and none for my daughter Lizzie. And like I mentioned before, you know, the instructional hours that she is receiving are far less in public school, than the instructional hours that are being received by my two other kids in private school now.

And we're really fortunate to have the resources to put our other children in private school. What we'd really like to be able to do is have those choices for all three of our kids. And I'm on calls frequently with children, or with families in eastern county Portland where these are all Title I schools, or you know in schools where kids have much fewer choices than the kids in our school district.

And you know this summer they're talking about grants and funding that's coming to the school districts for summer school and summer programs. And I guess I'm really grateful that there's some additional funds being allocated. But my question is, is that actually going to go to my daughter? Or is that going to actually

go to any of these kids who really need those funds and that education, and those extra supports?

Because so far, they're not opening, and they're not offering any of those programs to my kids, or to other kids in our area. And so, I think my biggest concern, I'm really grateful that I hear that more money is being allocated, but to date to get any of these services for our kids, has been a real fight.

Has been a real uphill battle. Like Lizzie still hasn't had a year, a full year, of no occupational therapy, no speech therapy, no physical therapy, all of it is delivered via telehealth, and as I think other witnesses have said, telehealth doesn't work for some kids with cognitive disabilities.

And so, I guess my question is if we continue to allocate funds, is that going to go to my child, or these needy children in some of these districts? Where is it going to go?

Mr. KELLER. That's actually a really good question because last year Congress provided more than 70 billion to schools, and you know when we look at the cost that has been put out there, it's been estimated through the Nation, it would be $422.00 per student on the high end, and that would amount to about 25 billion.

So, we've appropriated more than twice, almost three times what the estimate is. So, I'm just hopeful that the money will get to where it was designed to go, so kids like Lizzie can have the help they need to thrive. And thank you very much. I yield back.

Chairman SABLAN. Thank you. Thank you, Mr. Keller. Thank you very much. I now recognize Miss McBath, Lucy.

Ms. MCBATH. Thank you, Mr. Chairman. And I just wanted to say thank you to all of our witnesses today for your excellent testimony, and you're such grounded in this issue. And Ms. Dale, I just want to say I applaud you for such loving care and commitment toward Lizzie and your children. And I'm so sorry that that remark was made toward you because it's so apparent that you truly have done everything that you can to make sure that Lizzie has the care and resources that she needs for her education.

I do want to say though that this month President Biden signed the American Rescue Plan into law, giving schools across the country the funding and the resources that they so desperately need to make it through the COVID–19 pandemic. And the American Rescue Plan includes the biggest as we've said, it includes the biggest investment in the United States K through 12 education ever in history.

And in fact, the three school districts that are part of my congressional district here in Georgia, will be receiving about 676 million dollars from this vital legislation, and I couldn't be more happy for my district. This funding actually goes toward helping schools reopen safely, and equitably addressing learning loss to all of our students and helps our students to get back on track to achieving their post-secondary goals.

80 percent of the good-paying jobs that now require post-secondary education, and unfortunately COVID–19 is wreaking havoc on college enrollment rates. In this fall the percentage of high school graduates who went on to college immediately after high school fell by 22 percent. So, the decline in enrollment was nearly

twice as large for low-income high school graduates, then for their higher income peers.

And though there's always been a disconnect between high school and college, more students than ever, we know are falling into the cracks because of this pandemic. Mr. Carvalho, what should we be doing in the short-term and in the long-term to support students in making the transition from high school to post-secondary education, and how can funding from the American Rescue Plan Act be used to help them?

Mr. CARVALHO. Thank you very much for the question, Congresswoman. That is probably one of the most important questions I have heard today because it deals with the fact that 12th grade does not represent finality in the educational opportunity or journey of students. And we know that many students who graduate high school don't necessarily have a road toward a full secondary viable placement.

So, what can be done with these funds? Quite frankly, and I alluded to it during my early prepared remarks is No. 1, the identification of those students, particularly at the secondary level who are about to graduate but may not necessarily have the number of credits.

There are opportunities for credit recovery during the summer. Second, there are opportunities during the summer and the rest of the school year to engage students in career technical programming that is economically linked to the communities they live in. Third, there are opportunities to engage students in more actively participating in ACT and SAT preparatory programs that students in more affluent communities take for granted, giving them an additional chance at having access to this program, and those exams.

There are also opportunities that can be created during the spring break, the rest of the school year, and during the summer, that to go above and beyond the minimum requirements that the standards in any one State require. Preparing these students for success, whether it's college at 2-year technical school, college, or university.

In Miami-Dade I can tell you that we paid close attention to the post-secondary goals in the level of preparedness of our students, and we make the appropriate investments. We plan. With the ARP dollars, with these recovery investments, supplement our career technical programing, supplement or SAT and ACT preparation, supplement over the weeks and months that we have the additional credit recovery for students.

And also provide a repertoire of opportunities for these students, particularly those who are in high school right now to really solidify their proficiency level in areas that will make them, enable them to be successful in their post-secondary endeavors.

Ms. MCBATH. Thank you so much for that question. I am so sorry this is my dog in the background. And Ms. Almazan, over the summer and in the fall, I spoke with teachers in my district about their experiences with virtual learning. And they were very, very worried that their students, especially those with disabilities, and we're talking about these very students today, that they were going to fall behind because of the lack of in-person attention, as Mrs. Dale has just been so eloquently speaking about today, and that

they weren't able to get this kind of in-person learning through the virtual learning.

What steps has Secretary Cardona taken to reach out to the disability community, and ensure that disabled students are a priority when schools are considering reopening and these decisions?

Ms. ALMAZAN. Well Secretary Cardona reached out to us within the first week of him being confirmed, and he has been very open to the issues because he came from Connecticut, and he certainly understands the issues that diverse learners and equity present and challenge.

I want to say that there are a variety of places that have a addressed the issues of remote learning, places like Center for Learner Equity, Educating All Learners Alliance, COPAA is a partner. The National Center for Learning Disabilities, they all have resources and have created resources in the last year, and we look forward to working with Secretary Cardona as we try to address the needs of students with disabilities.

Chairman SABLAN. Thank you. Thank you, Miss McBath. Thank you. I'd now like to recognize again, try Mrs. Miller. Mrs. Miller? Mr. Cawthorn? Mr. Cawthorn? Mrs. Steel?

Mr. CAWTHORN. Mr. Chairman I apologize for that sir.

Chairman SABLAN. OK. Mr. Cawthorn, right?

Mr. CAWTHORN. Yes sir how are you doing.

Chairman SABLAN. We're good. You'll have five minutes.

Mr. CAWTHORN. That's good to hear. So, Mrs. Dale I sincerely appreciated your sentiments talking about your desire to open some of the schools and everything you are facing. I've got a disability myself, not necessarily a mental one, but a physical one, so I feel for your child who's having to go through this.

Can I ask you what is it like—the world like, for your daughter now really after going through a full year for being just alone and secluded from her friends in school?

Mrs. DALE. Thank you Representative Cawthorn. We're re-establishing routines now. We're trying to figure out where the gaps are, where the gaps exist, how to return some of that structure. We've actually hired a behavior specialist to come to our house and work with us a couple hours a week, because what happens when a child with a disability attends school is they get into a flow of structure and routine.

They're with peers and they use that peer modeling to learn, and when that routine is disrupted or changed, you know they lose a lot of those, they lose a lot of that structure. They lose a lot of that routine that really helps a child with a disability know how to navigate their day.

I think the other challenge that we're trying to overcome right now is just there's no physical education being provided in our schools, so while our schools have started to reopen in a hybrid format, there's no recess, and there's no PE, and that's something that you know kids in club sports, and kids in private—and I've got a daughter that's on a private dance team, children that have access to club activities like that, that a lot of students either vulnerable students of you know, low income, or students with disabilities like my daughter Lizzie don't have access to things like club sports.

You know schools are a place that they get to have physical education, so we're dealing with no just academic losses and friendships and other losses that we're dealing with you know physical challenges and things like you know, eating the right healthy foods, and getting the right amount of physical activity.

Mr. CAWTHORN. Right, well Jennifer thank you very much for taking your time to be able to speak with all of us. I do want to ask one more question. Do you think that some of the Federal Department of Education's funding you know to these states and other areas, should that be tied to schools reopening?

Mrs. DALE. I think very much so. Here in Oregon, you know, we kept being told that schools you know, once the teachers, once we hit certain metrics for COVID cases, schools would reopen. Once the teachers got vaccinated schools would reopen. Once, and so for parents feeling like you know it's going to happen, it's going to happen. In a couple of weeks from now for parents it kept feeling like we're going to open, we're going to open, and then it didn't.

And the teachers continued to get what they requested, and what they needed. And I am very supportive of teachers having vaccines and the States reopening, and the metrics being in the right you know, place for the community to be safe.

Mr. CAWTHORN. Yes.

Mrs. DALE. But what is hard for me as a parent, is what can I trust? What can I trust of the public school system? And that is why we've had to move two of our children to a private school system because I know what I'm going to get there, and I know what's going to happen.

And so, you know as money does come out to the public school system, which I also support because I know that's going to help my daughter but reopen.

Mr. CAWTHORN. Right of course.

Mrs. DALE. But we still haven't gotten a commitment to reopen.

Mr. CAWTHORN. Of course, well Ms. Dale thank you very much. And very quickly, I know I only have about 30 seconds left of this answer, but Mr. Morial, during your opening statement you were talking about how we need state-wide testing just to be able to tell where our students are at this time.

I was wondering, do you think coming out of this pandemic, do you think that we should continue to utilize these standardized tests, which you know I feel like some time is like asking a fish to climb a tree, whereas it doesn't mean the fish doesn't you know is talented, it just means he can't climb a tree.

Do you think that there could be a different form of testing that would be more beneficial for students?

Chairman SABLAN.Ten seconds.

Mr. MORIAL. Testing can always improve, but right now it's the best thing we have to see where our students are, not only to identify gaps within a school district, within a school, with the data you can tell whether the performance differentials are at the school level, at the classroom level, or within a particular school district within a State.

I think right now can testing improve—yes. But what we have now is better than nothing.

Mr. CAWTHORN. Mr. Morial thank you very much. Mr. Chairman I yield back.

Chairman SABLAN. Thank you. I think Miss Hayes of Connecticut has joined us, so Miss Hayes you have five minutes.

Ms. HAYES. Thank you, Mr. Chair. I appreciate you holding this very important hearing. I think it's safe to say that no one, if we had it our way, no one would want us to be in the situation that we're in now. And we want our children to be safe.

My son, actually his school went back to full in-person, and within two and a half weeks he's now home again for a 10-day quarantine because one of his classmates tested positive for COVID. And just today, my cousin who is at work asked me to leave the office to go get her daughter, because the teacher tested positive, and the school sent out a notice to parents that they're shutting down.

So, the idea that Democrats are OK with schools being closed is just a false choice. Every single one of us wants our children to go back to school. My questions today, Superintendent Carvalho, you made a statement about you at your school one of the things that they did was supplement the SAT and ACT testing. And I too am concerned about what the annual standardized tests look like for this year.

So, it's an issue that I continue to try to gather information on because in my district, and from my own perspective as a career educator, one of the things that I know is that these high-stakes, high pressure tests, which are our best tool for collecting information.

We've heard this year about all the gaps in learning that we've seen, so now for kids to be expected to perform at the highest level and be measured by these tests is deeply concerning, and I think will be unfairly punitive.

So, my question to you Superintendent Carvalho is as a superintendent of one of the largest school districts in the country, have you heard any concerns from your educators or parents surrounding the issue of standardized testing, or have you sought to seek feedback about how we can make this better, and make sure that the information is used in the way in which it is intended?

Mr. CARVALHO. Thank you very much for your question Representative Hayes. We certainly have. And No. 1, I'm sorry for what you described earlier, the impact of COVID on your family, and I would like to express also you know my absolute understanding and compassion for the testimony of Ms. Dale and what she has gone through.

Specifically, to your question, yes, I've heard from many parents, and from many educators, not only in Miami-Dade, but across the State and the country with certain significant concerns about standardized assessments this year. And not only the assessment itself, but toward what end do we assess, and will there be punitive actions and consequences as a result of that data.

We have taken a school board based on policy and administratively a number of steps we have communicated with our State regarding our concerns, specific to the utilization of tests dated this year for the reasons that you alluded to. And I'll just mention a couple more.

No. 1, COVID–19 has impacted differently different areas of the country, even within one State or one county, the impacts have been uneven. So, the expectation that the environmental educational conditions would be the same across the board for all students, all grade levels, all schools is just a fallacy.

Second, second the issue that was mentioned earlier, the quarantine impact on whole cohorts of students in schools has been desperate from school to school, sometimes within the same school. Certainly, across districts. What I'm referring to is that there will be an issue of validity and reliability associated with the data that will emanate from this year's standardized assessment.

That is why the Gold Standard of American Assessment, which is the NAEP, as an organization, as a board it canceled its administration for these very same reasons. Now in the State of Florida, and I understand what Mr. Morial said, and I agree. We need to know where our students are. We need to know where students are. We need to identify the gaps.

If, in fact, we are to develop strategies to eliminate those gaps and to accelerate students toward their full potential. So, we don't depend only on summative assessments, which are these standardized assessments at the end of the year, we also depend on formative assessments, on assessments delivered by teachers themselves, so that we know, rather than waiting until the end of the year, where our students are, where the gaps are, whether regression exists, where the learning loss is, and actively and timely intervene.

My hope is that as a result of our advocacy with a State, and on the basis of the waiver opportunity that the Federal Government has offered to the states, that to the extent that assessments are administered and the State of Florida that is moving forward with its assessments, that the window for assessments—

Ms. HAYES. I'm sorry, my time is about to run out. I don't mean to cut you off, but you just said everything that I know to be true. We saw that the SATs and ACTs in most places have been cutoff. And any good teacher is doing formative assessments on an ongoing basis, so I really hope that we have a more robust conversation so that we are in fact measuring what we are intended to measure.

Because my son's standardized test—standardize is we standardize everything about it. But it would be a measure of what I taught him this year and not his teacher, or his school. With that Mr. Chair I yield back.

Chairman SABLAN. Yes, thank you Jahana. Actually, my daughter as a teacher has told me that they are, at least she is, identifying students in her class who may need to go to summer school, and yes. So good work.

I'd like to let me see, Mrs. Miller, I think Mrs. Miller has joined us. Mrs. Miller?

Mrs. MILLER. Yes, thank you. I'm back, thank you I'm between multiple committees so.

Chairman SABLAN. Yes.

Mrs. MILLER. Thank you for bearing with. I have a question for Mrs. Dale. Mrs. Dale thank you for your testimony. And in your testimony, you shared that you began engaging in grass roots advocacy to get students back in school. I was wondering how your efforts were received by school board Members and law makers?

Mrs. DALE. Thank you for your question Representative Miller. In the beginning what we heard, so this is back in September and October when we launched some of these efforts, we got kind of form responses, template responses that said we're hearing an equal amount of people who want to go back, and people who don't want to go back.

And so the response in the beginning wasn't very optimistic that there would be a choice to return, but what we continually advocated for was that students who needed to go back, and needed that option to return to school, were given the choice to return, so that the comprehensive distance learning would continue for those teachers and staff and students that were doing OK in distance learning, but that the choice to return to in-person in a safe way was provided.

And there was a state-wide mandate in Oregon that was not lifted until January 1 of this year. And so, it was never even a possibility, or a consideration even at a local school levels.

Mrs. MILLER. So, may I ask another question? Why do you believe in light of the science being clear that reopening schools is safe? Why do you believe schools are not open?

Mrs. DALE. I think that's the hardest question for all of us as parents, but I think that two reasons. I think one is that from what I learned over the last six to seven months, and this was nothing that I had ever gotten involved in before. I'm very involved in my child's education, but not in this manner. But over the last six or seven months what we discovered was you know kids don't vote, and so there was really no child representation.

There wasn't anybody coming to the table to say this is what's happening with our children, and with our kids, and why are kids suffering. I think that was one issue, and I think the other issue is that—and I alluded to this just a little bit earlier, and said there are contracts in place with teachers, and with teachers? unions that really precluded our kids from having the opportunity and the choice to go back to school.

So, for example, you know there were work from home agreements that teachers had signed. Any time a school tried to reopen, so when our school district tried to reopen in February. The teacher's union went out and placed ads and went to the newspapers and said that it was being rushed, and that they weren't consulted with going back.

And so, they opposed returning to in-person learning. And so, I think that from our perspective is at least all I can really speak to is my perspective as a parent and for my kids is that there just wasn't—there is a lot of inertia around going back. There wasn't this leadership and effort to figure out well how do we make it possible for some of our kids to get back in-person learning.

Mrs. MILLER. Thank you Mrs. Dale and I yield back the balance of my time.

Chairman SABLAN. Thank you. Thank you, Mrs. Miller. Again, let me see I'm going to call out Mr. Cawthorn one more time. Mrs. Steel? All right Mr. Bowman, sir? Mr. Bowman? Going once, and now the most patient Full Committee Chair Member of Congress, Chairman Bobby Scott. Sir you have five minutes.

Mr. SCOTT. Thank you. Thank you, Mr. Chair. And first I'd like to respond to a comment in his opening statement by the Ranking Member. He talked about political interference. I certainly agree with his comments and would like to enter into the record an outline of the original CDC guidelines from meat packing plants, and then the final CDC guidelines after the Trump administration White House got involved, there's a stark difference.

And I would also like to enter into the record the present CDC guidelines about three feet difference. It doesn't say you can suddenly go to three feet. It says you can go to three feet if you are complying with other guidelines like mask wearing and everything else. I'd like those entered into the record.

Chairman SABLAN. Without objection.

Mr. SCOTT. Mr. Morial thank you Marc, whoops, well let me ask the superintendent from Dade County Mr. Carvalho. Comments have been made about the fact that money has been allocated to your district based on this Title I formula. Obviously, you've got a lot of money for your district that hadn't been, could not have possibly been budgeted.

Can we count on you showing a significant difference as a result of in terms of results, because of this money? You know it's a lot of money, and if we don't show some good results, we'll never hear the end of it, and I can assure you you'll never get that kind of money again. You're on mute.

Mr. CARVALHO. Thank you. Representative Scott you can count on me. You can count on me. You can count on the 40,000 employees of this school system and 20,000 dedicated teaching professionals to do so.

Look, I'm a recession superintendent. I lived through the Great Recession of 2008–2009 where we had to shave hundreds of millions of dollars from our budget, and had it not been for the race to the top investments, some of the soaring results that I described probably would not have happened.

And I can tell you that some of the best practices that arose from those investments are still being felt in this school system today. Second, we approach the decisions on the utilization of these resources very carefully, in full consultation with our board who the policy actually requires a plan, a time plan for the expenditures with an exact knowledge of how those investments are going to be made, toward what end, what is the expected objective, goal and benefit.

Mr. SCOTT. I'm sorry, limited time. We've talked about the chance of continuing the allocations. It's my understanding that the virtual of the money, although not spent, has been allocated. When you hired a teacher, how long do you hire a teacher for?

Mr. CARVALHO. Well sir, when we hire a teacher we hope to hire a teacher for a lifetime because of their commitment. The funds the way they've been earmarked to us, the first level ESSER I, we've spent 70 percent of those dollars.

We just received the second allocation under the previous administration, and we now know that the most massive investment in the history of education in this country, which for Miami-Dade exceeds about a billion dollars, has been announced. And we're going to absolutely be cautious, careful in monitoring those expenditures

and strategic to live up to your challenge to me, which is these dollars will make a difference in terms of accelerating every single student to their full potential.

Mr. SCOTT. A lot of comment has been made about the fact that the money hasn't been spent. When you hire a teacher today you don't actually spend the money in a certain time?

Mr. CARVALHO. No sir. School districts are, you're correct sir, school districts obviously annualize expenditures, but the expenditure is timed with its consumption, so obviously, on the first month of a teacher's work you would expect about one-eighth of that allocation to have been spent. But I can tell you one thing. There's a difference between expenditures and encumbered. A lot of funds have been spent. A lot of funds have been encumbered, but it is timed in accordance obviously with their utilization, particularly if funds are attached to professionals, to human beings.

Mr. SCOTT. I wanted to ask Marc Morial a question. I see he is back. At the end of his testimony, he was talking about the need for state-wide assessments. Can he explain why the Urban League is supporting state-wide assessments?

Chairman SABLAN. Yes, he seems to be on, but his camera is off.

Mr. MORIAL. No, I'm here.

Chairman SABLAN. Oh, there he is.

Mr. MORIAL. Yes, I had to take care of a personal matter. Congressman, thank you for your question. And I've heard the testimony. We could debate when a state-wide assessment should be taken, but we have to know where the gaps are. We have to understand where the disparities exist.

And school leaders also need, and parents need transparency. Certainly, it's going to demonstrate that many students have lost ground. But what that will do is it will, if you will, present, provide the evidence for the investments in the kinds of strategies to close these gaps.

And I think we'll demonstrate why continued investment in Title I and other, if you will, interventions and other supports, for students of color, the low- and moderate-income students, the English language learners, are so essential. We have to have tools. We cannot fly the plane without using radar.

Debate the when, whether it should happen in the beginning of next school year. Debate the specifics. I don't, I'm not in love with standardized tests. No one is. I have nightmares from taking the bar exam, still. But the point is, is we have to have common tools.

Teacher assessments are extremely valued, but not a common tool, and we need common tools to determine. I would certainly say there's a lot to debate about the methodology of testing, about the pressure on kids around testing, but we've got to have data, and I do not want disparities to be masked.

So, you don't know where they are. We don't understand how they play out. If we're going to be serious about addressing systemic inequities in this country.

Chairman SABLAN. Thank you.

Mr. SCOTT. Thank you. Mr. Chairman I'd like to ask unanimous consent to enter into the record a document published by the National Education Association in 2016 describing how you can do assessments, talking about eliminating high stakes testing, and pro-

viding more local and local controlled testing as we did and in Every Student Succeeds Act so that people will know that we're not talking about the imposition of standardized tests, we're talking about making sure that we have the assessments so we know where the learning has to take place.

We have provided accordingly the Title I formula, so the money is going where it's most needed. And you can't as business friends tell us, you can't manage what you don't measure.

Chairman SABLAN. Thank you without objection so ordered.

Mr. SCOTT. Appreciate it.

Chairman SABLAN. And Mr. Chairman your five minutes is up. Thank you. So, we'll do some housekeeping matters here. I would like to remind my colleagues that pursuant to committee practice, materials for submission to the hearing record must be submitted to the Committee Clerk within 14 days following the last day of this hearing, so by close of business on May 8 of 2021, preferably in Microsoft Word format.

The materials submitted must address the subject matter of the hearing and only a Member of the subcommittee, or an invited witness may submit materials for inclusion in the hearing record. Documents are limited to 50 pages each.

Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the Committee Clerk within the required timeframe, but please recognize that in the future that link may no longer work.

Pursuant to House rules and regulations, items for the record should be submitted to the clerk electronically by emailing submissions to *edandlabor.hearings@mail.house.gov*. Again, *edandlabor.hearings@mail.house.gov*. Member offices are encouraged to submit materials to the inbox before the hearing, or during the hearing at the time the Member makes the request.

Now again I want to thank all of our witnesses for their participation today. All of you made huge contributions, this subcommittee. And Members of the subcommittees may have some additional questions for you. And we ask the witnesses to please respond to these questions in writing. The hearing record will be held open for 14 days in order to receive these responses. I remind my colleagues that pursuant to committee practice, witness questions for the hearing record must be submitted to the Majority Committee Staff or Committee Clerk within 7 days.

The questions submitted must address the subject matter of the hearing. I now recognize the distinguished Ranking Member for a closing statement.

Mr. OWENS. OK one second here. Hold tight. Bear with me.

Chairman SABLAN. Mr. Owens, yes?

Mr. OWENS. Yes, 1 second. I'm having a little bit of—OK, OK. First of all, Mr. Chairman, thank you once again. Before I start, I'd like to kind of clear the record. A little narrative that I'm finding very disturbing over the decades about a race that I am so proud to be part of, and a history that I'm so proud to reflect upon.

That there was this narrative that for some reason because we're in a segregated community, that we were a hapless race that could never overcome the oppressive white race. I want to clear that. I

grew up in Tallahassee, Florida, the deep south, in a community that was remarkably successful.

Even though it was segregated, we had the same thoughts of our country that other communities did, even though we were not assimilating at the time, whether it be Italian or German, we loved our country, believed in democracy. And we believed in the tenets that made our community great, and we did not trust government.

We believe there's a God in heaven. We believe in education the family unit and capitalism was our way out and guess what? The 40s and 50s and 6's we proved that. So, I want everybody to remember these statistics as we've talked about my race, because it has been something that's happened since the 60's has gotten to where we are.

It's not the color of our skin it's not what happened 200 years ago. In the 40s, 50s, and 60s my community, a black community, led our country's growth in middle class. Men matriculated from college, men committed to marriage, it was 70 percent. So no, we didn't have the problems with the single mothers that we now have today.

Men knew was it was to man up and take care of their families. We also led our country in the growth of the middle class because we had the highest percentage of entrepreneurs, over 40 percent. So, once you keep that in context and now look at what's happened to our Nation, and what's happening to the lack of education we are not experiencing.

So that being said, and I also want to say this to Mr. Carvalho, I hope I've pronounced that right. Thank you for what you've done in Miami-Dade. Thank you. You represent so many of our great leaders and teachers. You truly do love your profession, and you've proved that in this last year. Unfortunately, there's so many people out there that take this profession and they don't.

And I would say to Jennifer, she would have loved to have had your kind of leadership up in her State, because Lizzie would have had a different result over the last year. OK, that being said, Mr. Chairman, thank you again for calling this hearing, for the witnesses to offer your expertise today.

This has really been a great hearing. But I am frustrated with a couple of things that I've heard. First, I'm frustrated that the answer from my democratic friends for what children have experienced this last year is just to dump a whole lot more money into the same system that's failed students for so many generations.

In 1992, Mr. Chairman, black 12th graders scored 24 points lower than white students in reading. In 2019 they scored 32 points lower, and in 2017 the Department of Education State of California stated that 75 percent of black boys could not pass standard reading and writing tests.

This has nothing to do with the color of their skin, it has to do with policies in the face of the teacher unions whose responsibility is to never allow this to happen. It blows my mind that Democrats seem to think that all they have to do is dump a whole lot of money into the same system that's failed us. We need to change that.

Second of all, I'm glad to see my Democrat friends are finally supporting the need to reopen schools. I welcome this conversation. But Mr. Chairman, our families do not need our words, they need our actions. When Republicans opposed requiring school districts to

reopen schools in order to receive Federal COVID aid, every single Democrat voted no.

Five times the Democrats voted no on reopening schools for all students. Your party voted no on reopening schools for the most vulnerable students, including students with disabilities. The Democrats voted no on allowing parents with children in closed schools to use their personal share of public funds to find other educational options.

Your party voted no when requiring teachers? unions and school districts to be transparent about reopening negotiations. And Democrats voted no on reopening when all teachers in a district had access to the vaccine. Five times, five times to show that Democrats believed in science.

Five times to show that Democrats care about the harm being done to our children. Five times to show Democrats newfound enthusiasm for reopening schools isn't based on a summarization that the party is in political peril, and five times Democrats said no.

So, Mr. Chair, I appreciate you holding these hearings. I appreciate the opportunity to amplify the impact that this last year has had on families. I hope my friends across the aisle will put into action behind words, these words, the next time they have an opportunity.

And the last point, I grew up again in Tallahassee. I was the third black to go to the University of Miami. I left there with a degree in biology. In my community in the 60s that was not weird. That was not unheard of. We expected success because we wanted to reflect greater on our community, on our race, and to succeed.

Today that would be about almost unbelievable that a black, young man could go play football and graduate with a degree that will be respected across our country. That should never happen in our country, and we need to make sure that those that are most at risk are given an opportunity like everybody else, no matter what their zip code is, to have the American dream of education and choice.

And thank you for those out there giving our kids across our country parents? choice this last year. That is truly the American way and I thank you for the opportunity. Mr. Chair I yield back.

Chairman SABLAN. Thank you. Thank you, Mr. Owens. And I'm not going to respond to your comments, but I want to thank our witnesses again for taking the time to be with us. Again, each one of you has made good, very good contributions to our hearing today.

Today's hearing confirm that the COVID–19 relief funding that Congress has secured over the last year has been critical, critical to addressing the immediate challenges of the pandemic for schools. We're not expecting that there would be miracles here, but they were immediate. They addressed the challenges, the additional challenges of COVID–19.

We also heard how the American Rescue Plan in particular, is finally providing schools with the funding they need to reopen classrooms safely, keep classrooms open, and help students overcome the far-reaching consequences of school closures.

Finally, our discussions confirm what we have heard from our relief efforts so far, that Congress must continue to target resources to the schools and students who need them most. School commu-

nities cannot fully recover from this pandemic unless we confront persistent educational disparities that has been exacerbated by the pandemic.

We certainly have a clear path to finally achieve educational equity as we slowly emerge from this global health emergency. I look forward to taking historic steps along with all of you, alongside my colleagues on both sides of the aisle to ensure that every student has access to an education that allows them to reach their full potential.

And I go back right now I remember the hearing we had like three Congress's ago and we had a GAO official testify about the status of Native American schools because somebody mentioned, I think it was Mr. Grothman mentioned, our families generation of how we should look at that. The status of Native American schools in our country, and it is embarrassing. It is so unfair to what we have done to the indigenous people of our America.

But I want to thank you all for this also, coming from the territories. It's not 10 o'clock to 6 in the morning, almost time for me to get up from bed, but so it's always good, very important meeting. Everyone thank you for joining us and this meeting is now adjourned. Thank you.

[Additional submissions by Mr. Scott follow:]

Argus Leader.

NEWS

CDC report on Smithfield COVID-19 outbreak in Sioux Falls was redone with 'watered down' recommendations

Bart Pfankuch South Dakota News Watch
Published 2:09 p.m. CT Oct. 2, 2020 | **Updated 2:10 p.m. CT Oct. 2, 2020**

The federal Centers for Disease Control and Prevention approved a final report on a massive COVID-19 outbreak at the Smithfield Foods plant in Sioux Falls, then retracted that report and redid a second final report with much less stringent worker-safety recommendations.

The first report was dated April 21, 2020, and included 15 pages of recommendations for improved safety. The second report, issued the next day, included many of the same recommendations but with added language stating that safety improvements were "discretionary and not required" to be implemented by Smithfield.

The second report also contains numerous references to safety measures that should be implemented only "if feasible" or "if possible," including whether sick employees should stay home, whether dirty or wet masks should be replaced, and whether protective barriers should be used to keep workers safe.

Earlier: OSHA fines Smithfield Foods for 'failing to protect employees' from coronavirus

The Smithfield pork processing plant in downtown Sioux Falls became the largest COVID-19 hotspot in the country in April; in all, about 929 workers and 210 close contacts of workers were known to be sickened, leading to four employee deaths, according to the Occupational Safety and Health Administration. Smithfield was fined $13,494 by federal regulators in early September.

The CDC sent in a team of inspectors to the Sioux Falls plant in mid-April to complete what is known as an "Epi Aid" investigation into the outbreak and to make safety recommendations. The review was requested by the South Dakota Department of Health.

A congressional inquiry has been launched to find out who is responsible for what Democratic lawmakers said is the "watering down" of the CDC report recommendations, and to discover why and when the changes to the first version of the report were made. A member of the House of Representatives who chairs a subcommittee on worker safety raised concerns on Sept. 30 that politics may have played a role in the rewriting of the CDC report.

Robert Redfield, head of the CDC, told a U.S. Senate committee in September that the changes were made simply to note that CDC safety recommendations are suggestions and not requirements. However, such notations were not made in past CDC reports, including a report on a COVID-19 breakout at a Colorado meat plant issued just two days before the release of the Smithfield report.

Study: Smithfield Foods cluster larger than first reported

News Watch has confirmed through congressional records that the South Dakota Department of Health was given a "pre-clearance draft" copy of the first version of the report by email on April 20, the day before the initial version was to be released.

Those records also indicate that officials from the Smithfield plant in Sioux Falls were also given a draft copy of the first version of the report before its release.

Officials with the health department, including Secretary Kim Malsam-Rysdon and epidemiologist Joshua Clayton, who is listed as the primary recipient of both CDC reports, did not respond to specific questions sent to them by News Watch.

Instead, health department spokesman Derrick Haskins said in an email to News Watch, "We would refer you to CDC for questions related to its report. Dr. Clayton, Sec. Malsam-Rysdon, and Governor Noem were primarily responsible for requesting the initial CDC and NIOSH support to help assess the COVID-19 mitigation practices at Smithfield Foods and disseminating the investigation findings from the report."

Changes softened safety recommendations

A News Watch line-by-line review of the two versions of the CDC reports on the Smithfield plant found 24 alterations from the first version to the second version.

The most substantive additions come on the first and fifth pages, with language added to the second version in two places that was not in the first version. Those two added passages both note that, "The recommendations in this memorandum are steps that Smithfield Foods may

want to consider implementing to address the conditions we identified at the plant. These recommendations are discretionary and not required or mandated by the CDC."

In the "Recommendations" section on Page 5, the initial report contains language that was removed from the second report, including that the following actions are recommended "to ensure that existing and future control efforts are effective in preventing the spread of COVID-19."

Later in that section, language in the first version states that Smithfield officials, the state health department and community partners "should develop an implementation plan for these and other interventions ... that should be rolled out in the workplace" to reduce the spread of COVID-19. The wording is changed in the second version to say that those groups should "work together to implement recommendations and plans" to reduce the spread.

In all, the second version of the report includes 14 references to implementing safety measures and procedures "where feasible," "if feasible" or "if possible."

The "if possible" or "wherever possible" statements are added in the second version to recommendations related to the following:

- Replacing dirty or wet facial coverings.
- Contactless distribution of face masks.
- Use of face masks to enhance worker protection.
- Asking workers about recent history of fever, cough or shortness of breath.
- Use of signs, in-plant messaging and clear language to educate workers on safety measures.

The "wherever feasible" or "if feasible" language was added to the second version of the report in relation to recommendations that:

- The plant eliminate transmission hazards.
- Physical barriers should be used in combination with social-distancing efforts.
- All employees should wear face coverings over their noses and mouths in all areas of the plant.
- Face shields should be used in addition to eye protection
- Hand-sanitizing stations should be located wherever employees take anything from a bin.

New safety guidance should be reviewed and implemented as it becomes available.

The second version of the report also changes the word "slaughtering" of animals in the first version to "harvesting" of animals in the second version.

The first version of the Smithfield report was reviewed and approved for publication by two separate CDC task forces; it was obtained by News Watch through the U.S. House Education and Labor Committee.

Inquiries about the two Smithfield reports have intensified as members of that committee and others have interviewed federal officials about COVID-19 and industry, and have asked follow-up questions about the Smithfield reports.

U.S. Rep. Dusty Johnson, R-S.D., is a member of that committee; a spokesperson for Johnson said on Oct. 1 that he was not aware of the two versions of the CDC report or any language changes being made.

Congressional Democrats seek answers

U.S. Rep. Alma Adams, D-N.C., chair of the House Subcommittee on Workforce Protections, said in a statement on Sept. 30 that she was unsatisfied with Redfield's statements as to why the new language appeared in the second version of the Smithfield report, and added that she was concerned that political considerations may have played a role in softening the CDC guidance.

"Dr. Redfield's explanation ... for why the CDC felt it was necessary to weaken the Epi Aid report language does not hold water, nor has the CDC provided Congress with any substantive reason for changing the report," Adams said. "Given the information we currently have, it appears as if politics played a role – ultimately leading the CDC to weaken critical workplace safety guidance putting workers' lives at risk. I am committed to finding out exactly who was involved in this decision, and why they did what they did."

Adams and three other Democrats who serve on labor and worker-safety committees in Congress sent letters on Sept. 28 to top officials at federal agencies involved in the Smithfield plant investigation, demanding answers to who altered the initial CDC report, when and why.

One letter, seeking information about the "watering down" of the CDC report on the Sioux Falls Smithfield plant COVID-19 outbreak, was sent from U.S. Sens. Tammy Baldwin, D-Wis., and Patty Murray, D-Wash., and U.S. Reps. Robert C. Scott, D-Va., and Alma Adams to Redfield of the CDC, Alex Azar of the Department of Health and Human Services and John Howard of the National Institute for Occupational Health and Safety.

The letter seeks information and correspondence related to the CDC investigation, the compiling of the two versions of the report and the involvement of any and all parties in making changes to the reports, including the South Dakota Department of Health and Smithfield Foods.

Those members of Congress also sent a letter that same day asking for similar information from Sonny Perdue, secretary of the Department of Agriculture.

In a press release announcing that the letters were sent, the members of Congress wrote that on Sept. 23, Redfield appeared before a Senate committee and "testified that he had no contact with the Department of Agriculture, the White House or Smithfield about this matter, which seems to contradict CDC officials who have confirmed an April 22 phone call between the CDC director and the USDA secretary."

Gov. Noem said on April 16 that she had been in close contact with USDA Secretary Perdue and officials from the Smithfield plant as the investigation into the outbreak was ongoing.

Noem told South Dakota media on April 22 that the USDA and CDC had been in contact with one another regarding the Smithfield investigation.

In response to questions about the two versions of the CDC report posed by News Watch on Sept. 30, Ian Fury, a spokesman for Noem, said, "It's the CDC's report, and we'll defer to them on how it was compiled."

When asked if Noem was consulted on the contents of the report at any time, Fury wrote, "She was heavily involved in getting the CDC to Smithfield for the purpose of providing recommendations so that the plant could reopen safely."

The initial report findings and recommendations, those made before the softening of the language, were sent by email on April 20, 2020, to the South Dakota Department of Health, executives of the Smithfield plant and a local union official in Sioux Falls, according to questioning by committee members on May 28 with answers provided by John Howard, director of the National Institute for Occupational Safety and Health.

The second, revised version of the Smithfield report was then sent to the South Dakota health department on April 22, Howard said.

"While the substance of CDC's recommendations did not change between the first and second version, a sentence was added at the beginning to clarify that this was not a

regulatory document and throughout there were some working changes (couched in "if phrases") to reinforce the non-regulatory nature of the report," Howard testified.

Smithfield says safety measures now in place

The changes to the Smithfield CDC report have become the subject of further discussion and questioning by some members of Congress.

The questions raised by congressional Democrats come amid concerns that the meat-packing industry played a big role in pushing for plants to stay open or to re-open during the pandemic. Several national news organizations have published emails showing that meatpackers and industry groups provided language that formed the basis of an executive order signed by President Donald Trump in late April declaring meat-processing companies to be "critical infrastructure" that needed to remain open during the pandemic, even as thousands of workers became infected.

The House Education and Labor Committee leadership, in a press release issued Sept. 30, noted that such statements, or "weakening phrases," are not included in any other CDC Epi Aid reports beyond the Smithfield report.

News Watch reviewed a similar Epi Aid report issued by the CDC after an investigation of a COVID-19 outbreak at the JBS USA beef processing plant in Greeley, Colo. That memorandum was issued on April 20, just one day before the release of the initial CDC report on the Smithfield plant in Sioux Falls.

The JBS memorandum, published in a similar format as the Smithfield memorandum, contains no language indicating the report recommendations are "discretionary" or "not required or mandated" or should be implemented only "if feasible" or "if possible."

For example, the second, softened version of the CDC memo on the Smithfield plant says that "employees who are ill should stay home if feasible," with the "if feasible" clause added after the revision of the first report.

Meanwhile, the JBS memo issued only two days earlier states that if plant workers have symptoms consistent with COVID-19, "they are told to return home, surrender their plant identification card, follow up with a telehealth provider" and be notified of available pay and benefits.

In the section outlining CDC safety recommendations, the JBS memo states, "The health and safety committee and labor representatives should develop an implementation plan for these

and any other interventions."

The two versions of the CDC report on the Smithfield plant were sent to company officials Russ Dokken, Scott Reed and Mark Wiggs as well as B.J. Motley, president of the local United Food and Commercial Workers Local 304A union in Sioux Falls. News Watch requests for comment to Motley were not answered.

In response to News Watch questions, Keira Lombardo, Smithfield Foods executive vice president for corporate affairs, said the company has cooperated fully with government inspectors and scientists during the pandemic and has spent $500 million on plant safety.

"We implemented a wide range of measures and protocols well in advance of any government guidance," Lombardo wrote in an email. "To be very clear, we have implemented CDC recommendations and guidance whether those recommendations and guidance are mandatory or not. Our measures have been working – active cases among our U.S. workforce are at a fraction of 1% and have been for a sustained period."

Haskins, of the health department, said the state provides updates on COVID-19 clusters when there are more than 40 cases in a single setting. The department has not reported on any new clusters at the Smithfield plant, Haskins said on Oct. 2.

The Washington Post
Democracy Dies in Darkness

The CDC softened a report on meatpacking safety during the pandemic. Democrats say they want to know why.

By **Eli Rosenberg**

September 30, 2020 at 9:53 p.m. EDT

A report from the Centers for Disease Control and Prevention about safety procedures at a meatpacking plant whose workers were falling ill at an alarming rate early on in the pandemic is raising new questions from Democrats about possible political interference at the agency.

On April 22, the CDC issued a report with basic health recommendations to control the spread of the novel coronavirus at a meatpacking plant run by Smithfield Foods in Sioux Falls, S.D.

The original version of the report put forth these recommendations about worker safety, according to a copy acquired by The Washington Post. But the final report sent to the plant included language that had been softened with qualifiers such as "whenever possible" and "if feasible."

The plant, which slaughters and processes pork, was one of the biggest coronavirus hot spots in the United States around that time; 904 cases and two deaths were linked to the plant as of April 21, according to the Argus Leader.

Democratic members of the House Committee on Education and Labor say they believe political pressure from the office of CDC Director Robert Redfield explains why some of the language in the report was changed.

They, along with Democratic senators from the Committee on Health, Education, Labor and Pensions, sent letters to the CDC and the Agriculture Department this week to request more information about why the changes were made and whether Smithfield Foods or additional federal agencies were involved.

"Given the information we currently have, it appears as if politics played a role — ultimately leading the CDC to weaken critical workplace safety guidance putting workers' lives at risk," said Rep. Alma Adams (D-N.C.), the chairwoman of the subcommittee on workforce protections. "I am committed to finding out exactly who was involved in this decision, and why they did what they did."

The CDC defended the move in a statement to The Post, saying the changes to the report better "reflected CDC's status as a non-regulatory agency," differentiating its role as a public health agency.

The report has been drawing attention for months, but it has come into focus recently amid questions about the ways

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Public Health, which had requested the CDC's help investigating infections at the Smithfield Foods plant.

The CDC, which visited the plant, noted some accommodations were being made to promote worker safety at the plant, such as temperature screenings and social distancing. And the CDC report suggested many recommendations of its own, such as reducing employee density in nonwork areas, staggering shifts and altering workspaces to further reduce close contact among employees.

The qualifying phrasing in the CDC report also showed up in the guidance for all meatpacking facilities in the United States that was released jointly by the agency along with OSHA just a few days later.

A few examples include: "Use physical barriers, such as strip curtains, plexiglass or similar materials, or other impermeable dividers or partitions, to separate meat and poultry processing workers from each other, if feasible"; and "Modify the alignment of workstations, including along processing lines, if feasible, so that workers are at least six feet apart in all directions (e.g., side-to-side and when facing one another), when possible."

The original version of the Smithfield report, which was first reported by MSNBC host Rachel Maddow, does not include the same amount of qualifying language.

For example, the words "feasible" and "possible" were used twice and 11 times in the original report. In the final report, the words were used nine and 20 times, respectively.

The final version of the report also included two new paragraphs that critics say weakened it, including this one: "The recommendations in this memorandum are steps that Smithfield Foods may want to consider implementing to address the conditions we identified at the plant. These recommendations are discretionary and not required or mandated by CDC."

"This is really unprecedented, in at least the decades of work I had," said former OSHA official Deborah Berkowitz, a worker safety expert at the National Employment Law Project. "Reports were always based on experts and scientists' findings about how to mitigate whatever hazard they were facing. This is clearly a case of the science being rewritten to appease political interests. ... And the result is that more workers got sick and died in the industry."

Tom Frieden, who led the CDC between 2009 and 2017, expressed a similar sentiment.

"The edits made are clearly meant to clearly weaken the recommendations put forth by the CDC," he said in an emailed statement. "Adding 'if feasible' and 'if possible' in many places reduces the strength of recommendations and also protects the company from liability."

House Democrats say they believe that the report was edited because of political pressure.

During a hearing last week, Sen. Tammy Baldwin (D-Wis.) asked Redfield why his office "demanded that the recommendations be watered down."

"I wouldn't characterize it the way that you did," he said, noting that the CDC does not have the power to regulate workplaces, as the Department of Labor and the Occupational Safety and Health Administration do. "We wanted to

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However, congressional investigators have been looking at the disclosure of an April 22 phone call between Redfield and Agriculture Secretary Sonny Perdue.

"The CDC Director and USDA Secretary have infrequent, but regular communication on issues related to public health and the intersection with food systems and agriculture," the CDC wrote in an email to a House Democrat's staffer this summer, disclosing the call. "To the extent that they discussed the report, the content of that discussion would be considered pre-decisional."

House Democrats noted in their letter to federal officials on Monday that Redfield's testimony seems to be in contradiction with the facts of the April 22 phone call.

In a statement distributed by spokesman Paul Fulton, the CDC said that it changed the text of the report to Smithfield because the original version "appeared regulatory in tone."

"The final memo more accurately reflected CDC's status as a non-regulatory agency and was the result of the critical review process at the agency," the CDC statement said.

Attention on the report has grown amid scrutiny of the Trump administration's track record on worker safety during the pandemic.

" 'They may.' 'If feasible.' 'If possible.' But nobody says, 'You have to do this,' " said Mark Lauritsen, director of the food processing, packing and manufacturing division at the United Food and Commercial Workers, which represents workers at the Smithfield plant. "That's been the problem since day one of the pandemic. These agencies controlled by the Trump administration are not putting the interests of the workers first — they're putting the industry first."

Smithfield Foods declined to answer questions about whether it had any involvement with the report but said it had invested more than $500 million in safety efforts at its many facilities in the United States.

"In navigating the extremely challenging circumstances caused by the virus, we have opened our facilities to government health and safety experts and scientists, and we have worked to ensure measures are in place to keep employees safe while we continue to produce food," Keira Lombardo, Smithfield's executive vice president for corporate affairs and compliance, said in a statement. "To be very clear, we implemented CDC recommendations and guidance whether those recommendations and guidance are mandatory or not."

OSHA, the federal agency charged with upholding worker safety, has defied worker advocates and appeased business groups by declining to issue a coronavirus safety standard for companies to adhere to.

Instead it has issued recommendations that are similarly softened with phrases like "if feasible."

While complaints about safety issues have poured in to the agency — it has received 9,139, according to recent data — it has only issued a handful of citations.

It recently cited Smithfield for its plant in South Dakota, where at least 1,294 workers have tested positive for the novel coronavirus and four have died, for one violation of failing to provide a workplace free from recognized hazards. Smithfield has said it plans to contest the $13,494 citation, **calling it "without merit."**

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The South Dakota Department of Public Health referred inquiries to the CDC.

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Democrats demand answers fr Labor Department on CDC recommendations for meatpac plant

BY ALEX GANGITANO - 10/07/20 12:57 PM EDT

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House and Senate Democrats called on Labor Secretary Eugene Scalia to provide information on the agency's involvement with recommendations from the Centers for Disease Control and Prevention (CDC) to a Smithfield meatpacking plant that had a COVID-19 outbreak.

Sen. Patty Murray (Wash.), the top Democrat on the Senate Health, Education, Labor and Pensions (HELP) Committee, and House Education and Labor Committee Chairman Bobby Scott (D-Va.) sent a letter to Scalia along with Sen. Tammy Baldwin (D-Wis.) and Rep. Alma Adams (D-N.C.).

The Smithfield Foods plant in Sioux Falls, S.D., was the site of a coronavirus outbreak in April. At least 1,294 Smithfield workers contracted the coronavirus, and four employees died from it.

CDC workers visited the plant that month and provided recommendations to reduce disease transmission. The Democrats claim that the recommendations were later withdrawn, watered down and then a final version was released.

The Democrats requested Scalia provide copies of all communications between the Labor Department and the CDC or Agriculture Department regarding a site visit to Smithfield.

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Biden faces decision time on eviction moratorium

The letter to request this information from Scalia follows CDC Director **Robert Redfield** last week telling Baldwin that his office was in contact with the Agriculture Department and Labor Department about the Smithfield outbreak.

Baldwin asked Redfield about these recommendations in a HELP Committee hearing last month and Redfield said at the time he had no contact with the Agriculture Department, White House or Smithfield on the matter.

The senators also requested copies of communications between Smithfield and the Labor Department, copies of reports of the in-person visit, a list of all versions of the visit memo, and copies of communications between the Labor Department and any other federal agency on the visit.

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CDC Centers for Disease Control and Prevention

Operational Strategy for K-12 Schools through Phased Prevention

COVID-19

Summary of Recent Changes

Updates as of March 19, 2021

- Revised physical distancing recommendations to reflect at least 3 feet between students in classrooms and provide clearer guidance when a greater distance (such as 6 feet) is recommended.
- Clarified that ventilation is a component of strategies to clean and maintain healthy facilities.
- Removed recommendation for physical barriers.
- Clarified the role of community transmission levels in decision-making.
- Added guidance on interventions when clusters occur.

View Previous Updates

Key Points

1. Evidence suggests that many K-12 schools that have strictly implemented prevention strategies have been able to safely open for in-person instruction and remain open.
2. CDC's K-12 operational strategy presents a pathway for schools to provide in-person instruction safely through consistent use of prevention strategies, including universal and correct use of masks and physical distancing.
3. All schools should implement and layer prevention strategies and should prioritize universal and correct use of masks and physical distancing.
4. Testing to identify individuals with SARS-CoV-2 infection and vaccination for teachers and staff provide additional layers of COVID-19 protection in schools.

Essential Elements of Safe K–12 School Operations for In-Person Learning

Schools are an important part of the infrastructure of communities, as they provide safe and supportive learning environments for students, employ teachers and other staff, and enable parents, guardians, and caregivers to work. Many students, staff, and caregivers are either missing or have had interruptions in services due to school building closures and virtual and hybrid learning. Evidence suggests that many K–12 schools that have strictly implemented prevention strategies have been able to safely open for in-person instruction and remain open.[1]

CDC's Science Brief on Transmission of SARS-CoV-2 in K–12 Schools summarizes evidence on COVID-19 among children and adolescents and what is known about preventing transmission in schools.

CDC has developed guidance for prevention strategies that K–12 school administrators can use to help protect students, teachers, and staff, and slow the spread of COVID-19. If prevention strategies are strictly adhered to, K–12 schools can safely open for in-person instruction and remain open.[1] This document provides an operational strategy for safe delivery of in-person instruction in K–12 schools through the integration of a package of prevention and control components:

1. Consistent implementation of layered prevention strategies to reduce SARS-CoV-2 transmission in schools
2. Consideration of indicators of community transmission to reflect levels of community risk
3. Phased prevention strategies based on levels of community transmission

The following public health efforts provide additional layers of COVID-19 protection in schools:

- Testing to identify individuals with a SARS-CoV-2 infection to limit transmission and outbreaks
- Vaccination for teachers and staff as soon as possible

Health Equity Considerations

Long-standing systemic health and social inequities have put many racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19. People who identify as American Indian/Alaska Native, Black, and Hispanic are disproportionately affected by COVID-19; these disparities have also emerged among children.[1] The absence of in-person educational options might disadvantage children from all backgrounds, particularly children in low-resourced communities who might be at an educational disadvantage. These students might be less likely to have access to technology to facilitate virtual learning and more likely to rely on key school-supported resources such as school meal programs, special education and related services, counseling, and after-school programs. Some parents and caregivers might have less-flexible jobs that do not permit staying at home to provide childcare and aid with virtual learning if schools are closed to in-person instruction. On the other hand, certain racial and ethnic groups have borne a disproportionate burden of illness and serious outcomes from COVID-19. These health disparities are evident even among school-aged children,[1] suggesting that in-person instruction might pose a greater risk of COVID-19 to disproportionately affected populations. For these reasons, health equity considerations related to in-person instruction are an integral part of this complex decision-making. To enable in-person learning in schools that serve racial and ethnic groups disproportionately affected by COVID-19, school administrators and public health officials can work together to help schools plan and implement comprehensive prevention strategies, engage community partners, and assist with referrals to medical care. It is important that these schools have the resources and technical assistance needed to adopt and diligently implement actions to slow the spread of the virus that causes COVID-19 among people inside the school and out in the community. Schools play a critical role in promoting equity in education and health for groups disproportionately affected by COVID-19.

Engagement with educators, families, and the school community

A successful and equitable school reopening strategy requires engaging the entire school community to establish a safe environment for all educators, school staff, and students and promote trust and confidence. School reopening planning should include:

- Administrators
- Teachers
- Student and parent representatives
- Specialized instructional support personnel (such as school counselors, school social workers, school psychologists, and nurses)
- Facilities managers and custodial staff
- Transportation personnel, school nutrition professionals, and family services representatives.

Consistent with health equity considerations, schools and school districts should conduct active and specific outreach to underserved families – including parents/guardians of students of color, students from low-income backgrounds, students with disabilities, English learners, students experiencing homelessness, and students in foster care. This communication

should be conducted in families' home languages or mode of communication and in alternate formats as needed to facilitate effective communication for individuals with disabilities and, where appropriate, in partnership with trusted community-based organizations.

Prevention Strategies to Reduce Transmission of SARS-CoV-2 in Schools

Regardless of the level of community transmission, **it is critical that schools use and layer** prevention strategies. Five key prevention strategies are essential to safe delivery of in-person instruction and help to prevent COVID-19 transmission in schools:

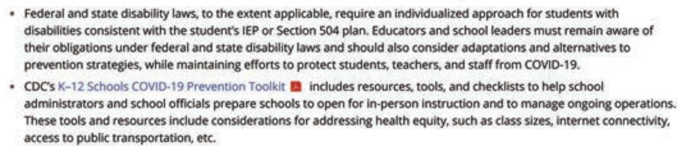
1. Universal and correct use of masks
2. Physical distancing
3. Handwashing and respiratory etiquette
4. Cleaning and maintaining healthy facilities
5. Contact tracing in combination with isolation and quarantine

Schools providing in-person instruction should prioritize two prevention strategies:

1. Universal and correct use of masks should be required
2. Physical distancing should be maximized to the greatest extent possible.

All prevention strategies provide some level of protection, and layered strategies implemented at the same time provide the greatest level of protection. Schools should adopt prevention strategies to the largest extent practical—a layered approach is essential.

Health equity considerations in prevention strategies



- Federal and state disability laws, to the extent applicable, require an individualized approach for students with disabilities consistent with the student's IEP or Section 504 plan. Educators and school leaders must remain aware of their obligations under federal and state disability laws and should also consider adaptations and alternatives to prevention strategies, while maintaining efforts to protect students, teachers, and staff from COVID-19.
- CDC's K-12 Schools COVID-19 Prevention Toolkit includes resources, tools, and checklists to help school administrators and school officials prepare schools to open for in-person instruction and to manage ongoing operations. These tools and resources include considerations for addressing health equity, such as class sizes, internet connectivity, access to public transportation, etc.

Universal and correct use of masks

Core principle for masks: Require consistent and correct use of well-fitting face masks with proper filtration by all students, teachers, and staff to prevent SARS-CoV-2 transmission through respiratory droplets. Masks should be worn at all times, by all people in school facilities, with certain exceptions for certain people, or for certain settings or activities, such as while eating or drinking. Masks should be required in all classroom and non-classroom settings, including hallways, school offices, restrooms, gyms, auditoriums, etc.

- **Mask policies** for all students, teachers, and staff set the expectation that people will use masks throughout the school.
- The most effective fabrics for cloth masks are tightly woven, such as cotton and cotton blends, breathable, and in two or three fabric layers. Masks with exhalation valves or vents, those that use loosely woven fabrics, and those that do not fit properly are not recommended.
- Most students, including those with disabilities, can tolerate and safely wear a mask. However, a narrow subset of students with disabilities might not be able to wear a mask or cannot safely wear a mask. Those who cannot safely wear a mask—for example, a person with a disability who, for reasons related to the disability, would be physically unable to remove a mask without assistance if breathing becomes obstructed—should not be required to wear one. For the remaining portion of the subset, schools should make individualized determinations as required by Federal disability laws in order to determine if an exception to the mask requirement is necessary and appropriate for a particular

student. If a child with a disability cannot wear a mask, maintain physical distance, or adhere to other public health requirements, the student is still entitled to an appropriate education, which in some circumstances may need to be provided virtually.

- Mask use should be required on school buses and other public transportation; school systems should take appropriate steps to ensure compliance with this requirement by students, staff, and others.
- If visitors are permitted in school, they should be required to wear masks at all times and should maintain physical distance from others.
- Schools should encourage modeling of correct and consistent mask use by school leaders, local leaders, and others respected in the community.

Physical distancing

Core principle for physical distancing: Establish school policies and implement structural interventions to promote physical distance between people.

- Between students in classrooms
  - In elementary schools, students should be at least 3 feet apart.[1]
  - In middle schools and high schools, students should be at least 3 feet apart in areas of low, moderate, or substantial community transmission. In areas of high community transmission, middle and high school students should be 6 feet apart if cohorting is not possible.[1,2, 4-6]
- Maintain 6 feet of distance in the following settings:
  - Between adults (teachers and staff), and between adults and students, at all times in the school building. Several studies have found that transmission between staff is more common than transmission between students and staff, and among students, in schools.[1]
  - When masks cannot be worn, such as when eating.
  - During activities when increased exhalation occurs, such as singing, shouting, band, or sports and exercise. Move these activities outdoors or to large, well-ventilated space, when possible.
  - In common areas such as school lobbies and auditoriums.
- Use cohorting, and maintain 6 feet of distance between cohorts where possible. Limit contact between cohorts. In areas of substantial (orange) and high (red) levels of community transmission, schools that use less than 6 feet between students in classrooms, cohorting is recommended, with at least 6 feet maintained between cohorts.
- Remove nonessential furniture and make other changes to classroom layouts to maximize distance between students.
- Face desks in the same direction, where possible.
- Eliminate or decrease nonessential in-person interactions among teachers and staff during meetings, lunches, and other situations that could lead to adult-to-adult transmission.
- **Visitors:** Limit any nonessential visitors, volunteers, and activities involving external groups or organizations as much as possible—especially with people who are not from the local geographic area (for example, not from the same community, town, city, county). Require all visitors to wear masks and physically distance from others.
- **Transportation:** Create distance between children on school buses (for example, seat children one child per row, skip rows), when possible. Masks are required by federal order on school buses and other forms of public transportation in the United States. Open windows to improve ventilation when it does not create a safety hazard. More information about school transportation and prevention is available.

Additional suggestions for physical distancing:

- **Staggered scheduling:** Stagger school arrival and drop-off times or locations by cohort, or put in place other protocols to limit contact between cohorts, as well as direct contact with parents.
- Alternate schedules **with fixed cohorts** of students and staff to decrease class size and promote physical distancing.

Handwashing and respiratory etiquette

Core principle for handwashing and respiratory etiquette: Through ongoing health education units and lessons, teach children proper handwashing and reinforce behaviors, and provide adequate supplies. Ensure that teachers and staff use proper handwashing and respiratory etiquette.

- **Teach and reinforce** handwashing with soap and water for at least 20 seconds and increase monitoring to ensure adherence among students, teachers, and staff. If handwashing is not possible, hand sanitizer containing at least 60% alcohol should be used.
- Encourage students and staff to cover coughs and sneezes with a tissue when not wearing a mask and immediately wash their hands after blowing their nose, coughing, or sneezing.
- Some students with disabilities might need assistance with handwashing and respiratory etiquette behaviors.
- **Adequate supplies:** Support healthy hygiene behaviors by providing adequate supplies, including soap, a way to dry hands, tissues, face masks (as feasible), and no-touch/foot-pedal trash cans. If soap and water are not readily available, schools can provide alcohol-based hand sanitizer that contains at least 60% alcohol (for staff and older children who can safely use hand sanitizer).

Cleaning and maintaining healthy facilities

Core principle for cleaning and maintaining healthy facilities: Make changes to physical spaces to maintain a healthy environment and facilities, including improving ventilation. Routinely and consistently clean high-touch surfaces (such as doorknobs and light switches).

- **Ventilation:** Improve ventilation to the extent possible to increase circulation of outdoor air, increase the delivery of clean air, and dilute potential contaminants. This can be achieved through several actions.
  - Bring in as much outdoor air as possible.
  - Ensure Heating, Ventilation, and Air Conditioning (HVAC) settings are maximizing ventilation.
  - Filter and/or clean the air in the school by improving the level of filtration as much as possible.
  - Use exhaust fans in restrooms and kitchens.
  - Open windows in buses and other transportation, if doing so does not pose a safety risk. Even just cracking windows open a few inches improves air circulation.
- **Modified layouts:** Adjust physical layouts in classrooms and other settings to maximize physical space, such as by turning desks to face in the same direction.
- **Cleaning:** Regularly clean frequently touched surfaces (for example, playground equipment, door handles, sink handles, toilets, drinking fountains) within the school and on school buses at least daily or between use as much as possible.
- **Communal spaces:** Close communal use of shared spaces, such as cafeterias, if possible; otherwise, stagger use and clean between use. Consider use of larger spaces such as cafeterias, libraries, gyms for academic instruction, to maximize physical distancing.
- **Food service:** Avoid offering any self-serve food or drink options such as hot and cold food bars, salad or condiment bars, and drink stations.
- **Shared objects:** Discourage sharing items, particularly those that are difficult to clean.
- **Water systems:** Take steps to ensure that all water systems and features (for example, sink faucets, decorative fountains) are safe to use after a prolonged facility shutdown.

Contact tracing in combination with isolation and quarantine

Core principle for contact tracing: Schools should collaborate with the health department, to the extent allowable by privacy laws and other applicable laws, to confidentially provide information about people diagnosed with or exposed to COVID-19. Students, teachers, and staff with positive test results should isolate, and close contacts should quarantine. Schools should report positive cases to the health department as soon as they are informed. School officials should notify families of close contacts as soon as possible after they are notified that someone in the school has tested positive (within the same school day).

- **Staying home when appropriate:** Educate teachers, staff and families about when they and their children should stay home and when they can return to school. Students, teachers, and staff who have symptoms should stay home and be referred to their healthcare provider for testing and care. Schools may need to consider flexible sick leave policies and practices that enable teachers and staff to stay home when they are sick, have been exposed, or are caring for someone who is sick. School systems should recruit and train sufficient substitute educators to ensure that teachers can stay home when they are sick or have been exposed to someone who is confirmed or suspected of having COVID-19.

- **Isolation** should be used to separate people diagnosed with COVID-19 from those who are not infected. Students, teachers, and staff who are in isolation should stay home and follow the direction of the local public health authority about when it is safe for them to be around others.
- **Case investigation and contact tracing:** Schools should work with the local health department to facilitate, to the extent allowable by applicable laws, systematic case investigation and contact tracing of infected students, teachers, and staff, and consistent isolation of cases and quarantine of close contacts. Schools can prepare and provide information and records to aid in the identification of potential contacts and exposure sites, consistent with applicable laws, including those related to privacy and confidentiality. Collaboration between the health department and K-12 school administration to obtain contact information of other individuals in shared rooms, class schedules, shared meals, or extracurricular activities will expedite contact tracing. For schools to remain open, health departments should ensure they have enough contact tracers to complete case investigation and notify contacts within 48 hours of a positive test result. Prompt identification, quarantine, and monitoring of those contacts exposed to SARS-CoV-2 can effectively break the chain of transmission and prevent further spread of the virus.
  - The definition of a close contact is someone who was within 6 feet of a person diagnosed with COVID-19 for a total of 15 minutes or more over a 24 hour period. The definition of a close contact applies regardless of whether either person was wearing a mask.
  - For schools that use less than 6 feet between students in classrooms, the definition of close contacts should not change. Students sitting less than 6 feet next to another student or person diagnosed with COVID-19 for a total of 15 minutes or more should quarantine at home and be referred for testing.
- **Quarantine** should be used for students, teachers, and staff who might have been exposed to COVID-19. Close contacts, identified through contact tracing, should quarantine unless they are fully vaccinated, or have tested positive in the last 3 months, and do not have any symptoms. Students, teachers, and staff who are in quarantine should stay home and follow the direction of the local public health department about when it is safe for them to be around others. If a child with a disability is required to quarantine, the school is required to provide services consistent with federal disability laws.

Indicators of Community Transmission

School administrators, working with local public health officials, should assess the level of community transmission to understand the burden of disease in the community. The higher the level of community transmission, the more likely that SARS-CoV-2 will be introduced into the school facility from the community, which could lead to in-school transmission if layered prevention strategies are not in use.

CDC recommends the use of two measures of community burden to determine the level of risk of transmission: total number of new cases per 100,000 persons in the past 7 days, and percentage of nucleic acid amplification tests (NAATs), including RT-PCR tests, that are positive during the last 7 days. The two measures of community burden should be used to assess the incidence and spread of SARS-CoV-2 in the surrounding community (for example, county) and not in the schools themselves. If the two indicators suggest different levels, the actions corresponding to the higher threshold (in Table 2) should be chosen. The transmission level for any given location will change over time and should be reassessed weekly for situational awareness and to continuously inform planning and decision-making.

Table 1. CDC Indicators and Thresholds for Community Transmission of COVID-19[1]

Indicator	Low Transmission Blue	Moderate Transmission Yellow	Substantial Transmission Orange	High Transmission Red
Total new cases per 100,000 persons in the past 7 days[2]	0-9	10-49	50-99	≥100

Indicator	Low Transmission Blue	Moderate Transmission Yellow	Substantial Transmission Orange	High Transmission Red
Percentage of NAATs that are positive during the past 7 days[3]	<5.0%	5.0%-7.9%	8.0%-9.9%	≥10.0%

[1]If the two indicators suggest different levels, the actions corresponding to the higher threshold should be chosen. County-level data on total new cases in the past 7 days and test percent positivity are available on the County View tab in CDC's COVID Data Tracker.
[2]Total number of new cases per 100,000 persons within the last 7 days is calculated by adding the number of new cases in the county (or other community type) in the last 7 days divided by the population in the county (or other community type) and multiplying by 100,000.
[3]Percentage of positive diagnostic and screening NAATs during the last 7 days is calculated by dividing the number of positive tests in the county (or other administrative level) during the last 7 days by the total number of tests resulted over the last 7 days. Additional information can be found on the Calculating Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Laboratory Test Percent Positivity: CDC Methods and Considerations for Comparisons and Interpretation webpage.

Phased Prevention

A phased prevention approach for K–12 schools relies on several core concepts.

- **K–12 schools should be the last settings to close after all other prevention measures in the community have been employed, and the first to reopen when they can do so safely.** This implies that decision-makers and communities should prioritize schools for reopening and remaining open for in-person instruction over nonessential businesses and activities, including indoor dining, bars, social gatherings, and close contact sports **as community transmission is controlled.**
- **In-person instruction should be prioritized over extracurricular activities, including sports and school events, to minimize risk of transmission in schools and protect in-person learning.** Prolonged periods of remote or virtual learning can have negative effects on educational progress for students, potentially slowing or reversing academic gains. Students from low-resourced communities, English learners, and students with disabilities might disproportionately experience learning loss due to limited access to remote learning technology and fewer learning support systems and services outside of schools. Safe in-person schooling can also offset the negative social, emotional, and mental health impacts of prolonged virtual learning. Minimizing the risk of spread during extracurricular activities and social gatherings outside of school can help maintain in-person instruction. Some close-contact sports might not be able to be implemented at any level of community transmission given the risk of transmission and the inability to implement prevention strategies.[1] Schools may consider using expanded screening testing for sports and extracurricular activities to identify cases and reduce risk of transmission from people who are asymptomatic or pre-symptomatic.
- **Lower susceptibility and incidence among younger children compared to teenagers suggests that younger students (for example, elementary school students) are likely to have less risk of in-school transmission due to in-person learning than older students (middle schools and high schools).** In addition, younger children may benefit more from in-person instruction and are less independent than older students.
- **Families of** students who are at increased risk of severe illness **(including those with special healthcare needs) or who live with people at high risk should be given the option of virtual instruction, regardless of the mode of learning offered.**
- **Schools are encouraged to use cohorting,** especially in areas of substantial (orange) and high (red) transmission, to facilitate testing and contact tracing, and to minimize transmission across cohorts.

Monitoring levels of community transmission provides school leaders with an indicator system for the risk of introduction of SARS-CoV-2 virus into a school. Information about levels of community transmission should be combined with information about cases in schools and implementation of prevention strategies to guide decision-making. Implementation of prevention strategies should be intensified if indicators worsen (i.e., moving from low to moderate to substantial to high community transmission). Intensifying prevention might also involve imposing restrictions on sports and extracurricular activities to protect in-person learning. To make decisions about preventive actions, school and health officials should take the following information into account:

- The numbers of COVID-19 cases among students, teachers, and staff, and number of people in quarantine

- Compliance with prevention strategies
- Levels of community transmission

Table 2 presents a school operational plan for opening and remaining open that emphasizes layering prevention at all levels of community transmission.

Table 2. Recommended Prevention Strategies for K-12 Schools and Levels of Community Transmission

Prevention Strategies: All Schools

All schools implement 5 key prevention strategies:

- Universal and correct use of masks required
- Physical distancing
- Handwashing and respiratory etiquette
- Cleaning and maintaining healthy facilities
- Contact tracing in combination with isolation and quarantine

Prevention Strategies by Level of Community Transmission

Low Transmission[1] Blue	**Moderate Transmission Yellow**	**Substantial Transmission Orange**	**High Transmission Red**
Elementary Schools Physical distancing: at least 3 feet between students in classrooms		**Elementary Schools** Physical distancing: at least 3 feet of distance between students in classrooms Cohorting[2] recommended when possible	
Middle and High Schools Physical distancing: at least 3 feet between students in classrooms		**Middle and High Schools** Physical distancing: at least 3 feet of distance between students in classrooms Cohorting recommended when possible	**Middle and High Schools** Schools that can use cohorting: at least 3 feet of distance Schools that cannot use cohorting: at least 6 feet distance between students in classrooms [3]
Sports and extracurricular activities Sports and extracurricular activities occur with at least 6 feet of physical distance to the greatest extent possible[6]	**Sports and extracurricular activities** Sports and extracurricular activities occur with at least 6 feet of physical distance required[6]	**Sports and extracurricular activities** Sports and extracurricular activities occur only if they can be held outdoors, with more than 6 feet of physical distancing[6]	

[1]Levels of community transmission defined as total new cases per 100,000 persons in the past 7 days (low, 0-9; moderate, 10-49; substantial, 50-99; high, ≥100) and percentage of positive tests in the past 7 days (low, <5%; moderate, 5-7.9%; substantial, 8-9.9%; high, ≥10%).
[2]Cohorting involves creating groups of students that are separated from other groups by at least 6 feet throughout the entire day. Cohorting can be implemented in either full in-person instruction or hybrid instruction, or through other strategies.
[3]In middle and high schools, 6 feet is recommended in areas of high community transmission, unless they can implement cohorting. Schools may consider using reduced attendance, hybrid instruction, or other strategies to ensure 6 feet of physical distance between students in middle and high schools that do not use cohorting. Diagnostic testing for SARS-CoV-2 is intended to identify occurrence of SARS-CoV-2 infection at the individual level and is performed on individuals

with or without suspected COVID-19 infection in accordance with the test's authorization and labeling.
[4]Middle and high schools in areas of high community transmission should implement cohorting if they use less than 6 feet between students in classrooms. If cohorting is not possible, 6 feet between students is recommended. Middle and high schools can use strategies such as reduced attendance (some students are virtual only at all times) or hybrid instruction to achieve 6 feet of distance.
[5]School officials should implement limits on spectators and attendees for sports, extracurricular activities, and events to ensure 6 feet of physical distance and require use of masks.
[6]Schools may consider using screening testing for student athletes and adults (e.g., coaches, trainers) who support these activities to facilitate safe participation and reduce risk of transmission. See screening testing section and Table 4 for additional details.

Monitoring cases and making decisions about in-person instruction

Schools should closely and regularly monitor the numbers of students, teachers, and staff with COVID-19, as well those in isolation and in quarantine. In collaboration with the local health department, decisions should combine information about levels of community transmission with school-specific factors, such as implementation of prevention strategies and the number of cases among students, teachers, and staff. Schools may consider convening a team or committee with representation from local public health and members of the school community (for example, students, parents, teachers, and staff) to review data regularly, share information, and discuss opportunities to support open communication with school stakeholders. As levels of community transmission increase, schools should further strengthen prevention strategies and monitor cases to reassess decisions.

Interventions to control clusters

A school **cluster** is an index case and two or more cases epidemiologically linked to the index case who likely acquired SARS-CoV-2 infection in school (i.e., school-associated cases). When cases are introduced into the school environment, they can lead to clusters and potentially to rapid and uncontrolled spread. This is more likely to happen in areas of substantial or high community transmission, as cases are more likely to be introduced into the school from the community. Schools should monitor cases (consistent with privacy and other applicable laws), identify clusters quickly, and promptly intervene to control spread. Infection source and whether the infection is likely acquired in school or outside of school should be determined by case investigations conducted by a collaboration between school administration and the local health department.

Schools should take the following actions to control transmission in the event of a cluster:

1. Investigate cases and trace contacts; encourage isolation and quarantine (consistent with applicable privacy and other laws).
   - Work with the health department to carefully investigate each case, including conducting interviews with students, teachers, parents, and school staff.
   - Encourage compliance with isolation for people who test positive.
   - Work with the health department to trace close contacts in accordance with applicable federal and state privacy laws of all cases and refer close contacts for diagnostic testing. Encourage compliance with quarantine.
2. Assess situations where close contacts occurred and implement interventions to address potential contributors to the clusters. For example:
   - Determine whether inconsistent or incorrect use of masks contributed to the clusters and intervene to improve consistent and correct mask use.
   - Assess implementation of physical distancing and determine whether intervention is needed to address distancing.
   - Eliminate or decrease nonessential in-person interactions among teachers and staff during meetings, lunches, and other situations that may have led to adult-to-adult transmission.

Unplanned school closures

Despite careful planning and consistent implementation of prevention strategies, some situations may lead school officials to consider temporarily closing schools or parts of a school (such as a class, cohort, or grade level) to in-person instruction, typically in consultation with the local health department. These decisions should be made based on careful consideration of a variety of factors and with the emphasis on ensuring the health and wellness of students, their families, and teachers and staff. In such cases, schools should make efforts to provide continuity of instruction through synchronous remote learning or

at-home activities.

Classrooms, cohorts, or schools experiencing uncontrolled spread of COVID-19 may temporarily close for in-person learning. If the school is experiencing uncontrolled spread, school leaders should immediately notify public health officials and collaborate to facilitate increased testing and contact tracing, as necessary. The local health department may facilitate testing for students, teachers, and staff who are in schools with an uncontrolled spread.

Schools in areas experiencing rapid or persistent rises in COVID-19 case rates or severe burden on health care capacity. School leaders and public health officials should monitor indicators of community transmission (Table 1) and review trends over time. In communities that have rapid or persistent rises in COVID-19 incidence or severe healthcare capacity burden, school leaders may decide to temporarily close schools to in-person instruction until levels of community transmission stabilize.

Providing options for teachers and school staff

At all levels of community transmission, employers should provide reassignment, remote work, or other options for teachers and staff who have documented high-risk conditions that place them at increased risk for severe illness from COVID-19 to limit the risk of workplace exposure. When these conditions are disabilities under the Americans with Disabilities Act, employers should ensure compliance with law and may need to consider providing reasonable accommodation subject to undue hardship. Options for reassignment may include but are not limited to telework, virtual teaching opportunities, modified job responsibilities, environmental modifications, scheduling flexibility, or temporary reassignment to different job responsibilities. These options should likewise be extended to teachers and staff who have a household member who is at increased risk for severe illness from COVID-19. Policies and procedures addressing issues related to teachers and staff at higher risk of serious illness and the application of reassignment, remote work, or other options for prevention should be made in consultation with occupational medicine and human resource professionals with knowledge of the specific situation, keeping in mind Equal Employment Opportunity (EEO) and other potential legal concerns. Schools should work with local counsel to ensure compliance.

New COVID-19 variants and prevention in schools

Multiple SARS-CoV-2 variants are circulating globally. These include several variants that have been detected in the United States. Some of these variants seem to spread more easily and quickly than other variants, which could lead to more cases of COVID-19. Rigorous implementation of prevention strategies is essential to control the spread of variants of SARS-CoV-2. CDC, in collaboration with other public health agencies, is monitoring the situation closely and studying these variants quickly to learn more to control their spread. As more information becomes available, prevention strategies and school guidance may need to be adjusted to new evidence on risk of transmission and effectiveness of prevention in variants that are circulating in the community.

Health equity considerations in phased prevention

- Schools that serve student populations that are at greater risk for learning loss during virtual instruction (for example, due to their more limited access to technology) should be prioritized for providing in-person instruction and be provided the needed resources to implement prevention.
- Schools should consider prioritizing in-person instruction for students with disabilities who require special education and related services directly provided in school environments, as well as other students who may benefit from receiving essential instruction in a school setting.
- Schools should develop plans to continue meal service provision, such as free breakfast and lunch to families for every learning mode, including in-person, hybrid, and virtual.

Additional COVID-19 Prevention Strategies in Schools

Testing

Viral testing strategies in partnership with schools should be part of a comprehensive prevention approach. Testing should not be used alone, but in combination with other prevention to reduce risk of transmission in schools. When schools implement testing combined with prevention strategies, they can detect new cases to prevent outbreaks, reduce the risk of further transmission, and protect students, teachers, and staff from COVID-19.

Diagnostic Testing

At all levels of community transmission, schools should offer referrals to diagnostic testing to any student, teacher, or staff member who is exhibiting symptoms of COVID-19 at school. Diagnostic testing for SARS-CoV-2 is intended to identify occurrence of SARS-CoV-2 infection at the individual level and is performed when there is a reason to suspect that an individual may be infected, such as having symptoms or suspected recent exposure. Examples of diagnostic testing strategies include testing symptomatic teachers, students, and staff who develop symptoms in school, and testing asymptomatic individuals who were exposed to someone with a confirmed or suspected case of COVID-19. Additional considerations for diagnostic testing:

- Schools should advise students, teachers, and staff to stay home if they are sick or if they have been exposed to SARS-CoV-2. Schools can encourage these individuals to talk to their healthcare provider about getting a COVID-19 test.
- If a student, teacher, or staff member becomes sick at school or reports a new COVID-19 diagnosis, schools should follow the steps of the COVID-19 Diagnosis flowchart on what to do next. This includes notifying a student's parent or guardian and initiating testing strategies. Notifications must be accessible for all students, parents, or guardians, including those with disabilities or limited English proficiency (for example, through use of interpreters or translated materials).
- In some schools, school-based healthcare professionals (for example, school nurses) may perform SARS-CoV-2 antigen testing in school-based health centers if they are trained in specimen collection, conducting the test per manufacturer's instructions, and obtain a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver . Some school-based healthcare professionals may also be able to perform specimen collection to send to a lab for testing, if trained in specimen collection, without a CLIA certificate. It is important that school-based healthcare professionals have access to, and training on the proper use of personal protective equipment (PPE).
- Not every school or school-based healthcare professional will have the staff, resources, or training to conduct testing. Public health officials should work with schools to help link students and their families, teachers, and staff to other opportunities for testing in their community. Testing could be offered by referral to community-based testing sites, through collaboration with local public health, or through a centralized test location offered by the school district.

The presence of any of the symptoms below generally suggests a student, teacher, or staff member has an infectious illness and should not attend school, regardless of whether the illness is COVID-19. For students, staff, and teachers with chronic conditions, symptom presence should represent a change from their typical health status to warrant exclusion from school. Occurrence of any of the symptoms below while a student, teacher, or staff member is at school suggests the person may be referred for diagnostic testing.

- Temperature of 100.4 degrees Fahrenheit or higher
- Sore throat
- Cough (for students with chronic cough due to allergies or asthma, a change in their cough from baseline)
- Difficulty breathing (for students with asthma, a change from their baseline breathing)
- Diarrhea or vomiting
- New loss of taste or smell
- New onset of severe headache, especially with a fever

Students should not attend school in-person if they or their caregiver identifies new development of any of the symptoms above.

Schools can provide options to separate students with COVID-19 symptoms or suspected or confirmed COVID-19 diagnoses by, for example, placing students in isolation room/areas until transportation can be arranged to send them home or seek emergency medical attention.

If a COVID-19 diagnosis is confirmed, schools can support public health officials in determining which close contacts and other potentially exposed persons in the school setting could be tested and either isolated or quarantined (see Table 3). Schools can assist by providing information, where appropriate, to identify close contacts (for example, class rosters, seating charts, and information to facilitate outreach to contacts).

Table 3. Tiered approach of diagnostic testing for SARS-CoV-2[1,2]

Students, teachers, and staff with symptoms of COVID-19 **Refer for diagnostic testing**	Students, teachers, or staff with symptoms of COVID-19 at school, at all levels of community transmission. • Individuals with positive test results should go to their home and isolate until they have met criteria for release from isolation. • People with symptoms should be isolated away from others as soon as symptoms appear and sent home. Those with positive test results should remain in isolation until they have met all three criteria for release: 10 days have passed since symptom onset; at least 24 hours have passed since resolution of fever without medication; and other symptoms have improved. CDC does not recommend that people be tested again before leaving isolation because people who have recovered can test positive for several weeks without being contagious. If an individual with symptoms tests negative, they should still stay home until their symptoms resolve to avoid spreading any SARS-CoV-2 or other infection.
Close contacts **Refer for diagnostic testing**	Students, teachers, or staff who had contact with someone diagnosed with COVID-19, defined as someone who has been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period. The definition of a close contact applies regardless of whether either person was wearing a mask. The definition also applies in schools that use less than 6 feet between students in classrooms. Families of close contacts should be notified and referred for testing immediately. • Regardless of the test result, close contacts should quarantine for 14 days. Based on local circumstances and resources, options to shorten quarantine provide acceptable alternatives of a 10-day quarantine or a 7-day quarantine combined with testing. • To minimize impact of quarantines on delivery of instruction, schools should limit the potential for exposures across cohorts and classrooms (for example, teachers should limit close contacts with other teachers and with students not in their own classrooms). • People who are fully vaccinated or were previously diagnosed with COVID-19 within the last three months may not need to quarantine.

[1]The tiers above are intended to be applied across all levels of community transmission: low (blue), moderate (yellow), substantial (orange), and high (red).

[2] information should be provided with appropriate safeguards to protect personally identifiable information and HIPPA-sensitive information from unlawful release.

For diagnostic testing, selection of tests should prioritize tests with highly accurate results with high sensitivity and specificity such as NAATs. Referral to diagnostic testing for students, teachers, and staff who have symptoms of COVID-19 at school and for close contacts is recommended for all levels of community transmission. Students, teachers, and staff who have diagnostic testing performed should be isolated away from others and quarantined at home until test results are received. Diagnostic testing turnaround times depend on the type of test and the laboratory conducting it. Local capacity in diagnostic tests should ensure that people with suspected COVID-19 and their contacts are tested with results returning within 48 hours. At low levels of community transmission (blue), schools should refer students, teachers, and staff with symptoms or recent history of close contact with a confirmed case for diagnostic testing to identify or rule out SARS-CoV-2 infection. At moderate (yellow), substantial (orange), and high (red) levels, and at low (blue) levels for teachers and staff, referral to diagnostic testing is combined with screening testing to monitor any increases in infection rates.

For students, teachers, and staff who had previously received positive test results and do not have symptoms of COVID-19, retesting is not recommended for up to 3 months from their last positive test result. Data currently suggest that some individuals persistently test positive due to residual virus material but are unlikely to be infectious. Parents or guardians can request documentation from their healthcare provider to indicate the date and type of the student's most recent COVID-19 test. Guidance on testing strategies for people who are fully vaccinated will be updated as more information becomes available. As vaccine supply increases and more teachers and staff receive vaccine, CDC's priorities for SARS-CoV-2 testing will change and the guidance will be updated.

Screening Testing

Some schools may also elect to use screening testing as a strategy to identify cases and prevent secondary transmission. Screening testing involves using SARS-CoV-2 viral tests (diagnostic tests used for screening purposes) intended to identify occurrence at the individual level even if there is no reason to suspect infection—i.e., there is no known exposure and no symptoms. This includes, but is not limited to, screening testing of asymptomatic people without known exposure with the intent of making decisions based on the test results. Screening testing is intended to identify infected people without symptoms (or before development of symptoms) who may be contagious so that measures can be taken to prevent further transmission. The intent is to use the screening testing results to determine who may return to in-person school or work and the protective measures that will be taken, and to identify and isolate positive persons to prevent spread.

Screening testing is particularly valuable in areas with moderate, substantial, and high levels of community transmission. Screening testing for K–12 schools may allow schools to move between different testing strategies as community prevalence (and therefore risk assessment) changes. Screening testing could provide added protection for schools that use less than 6 feet of physical distancing between students in classrooms. For schools that implement it, screening testing should be offered at moderate (yellow), substantial (orange), and high (red) levels of community transmission, to students, teachers, and staff, and at low (blue) levels to teachers and staff. Achieving substantial reduction in transmission with testing requires more frequent testing and shorter lags between test administration and reporting of results.

Schools may consider using pooled testing as a screening testing strategy for students. Pooled testing involves mixing several samples from different individuals together in a "batch" or pooled sample, then testing the pooled sample with a diagnostic test. This approach increases the number of individuals that can be tested and reduces the need for testing resources. This approach may be particularly helpful in schools using cohorts. Because of the complexities of acting on a positive result, pooled testing is best used in situations where the number of positives is expected to be very low. Cohorts could be established in grade groups, such as all students in a particular grade or in similar grades (for example, K–grade 2; grades 3–5). If a confirmed positive case is found, close contacts of anyone in that cohort should be quarantined and tested.

Table 4. Testing Recommendations by Level of Community Transmission

<table>
<tr><td colspan="4">Testing Recommendations: All Schools</td></tr>
<tr><td colspan="4">Diagnostic testing[1]: Symptomatic students, teachers, and staff and close contacts referred for diagnostic testing
Screening Testing for teachers and staff: expanded screening testing[3] of teachers and staff offered at least once per week</td></tr>
<tr><td colspan="4">Testing Recommendations by Level of Community Transmission</td></tr>
<tr><td>Low Transmission[1]
Blue</td><td>Moderate Transmission
Yellow</td><td>Substantial Transmission
Orange</td><td>High Transmission
Red</td></tr>
<tr><td>No screening testing for students</td><td colspan="3">Screening testing for students: expanded screening testing of students [4] offered at least once per week</td></tr>
<tr><td colspan="2">Testing for high-risk sports:[5] for schools conducting routine testing for sports, testing is recommended at least once per week
Testing for low and intermediate-risk sports: for schools conducting routine testing for sports, testing is recommended at least once per week</td><td colspan="2">Testing for high-risk sports: for schools conducting routine testing for sports, testing is recommended twice per week
Testing for low and intermediate-risk sports: for schools conducting routine testing for sports, testing is recommended at least once per week</td></tr>
</table>

[1]Diagnostic testing for SARS-CoV-2 is intended to identify occurrence of SARS-CoV-2 infection at the individual level and is performed when there is a reason to suspect that an individual may be infected, such as having symptoms or suspected recent exposure.

[1]Screening testing is intended to identify infected asymptomatic individuals who may be contagious so that measures can be taken to prevent further transmission.

[3]Levels of community transmission defined as total new cases per 100,000 persons in the past 7 days (low, 0-9; moderate, 10-49; substantial, 50-99; high, ≥100) and percentage of positive tests in the past 7 days (low, <5%; moderate, 5-7.9%; substantial, 8-9.9%; high, ≥10%).

[4]Schools may consider testing a random sample of at least 10% of students or may conduct pooled testing of cohorts/pods for screening testing in areas of moderate and substantial community transmission.

[5]Schools may consider using screening testing for student athletes and adults (e.g., coaches, teacher advisors) who support these activities to facilitate safe participation and reduce risk of transmission. For an example risk stratification for sports, see https://ncaaorg.s3.amazonaws.com/ssi/COVID/SSI_ResocializationDevelopingStandardsSecondEdition.pdf.

When combined with prevention measures, such as mask use, physical distancing, and others, testing protocols might be an effective tool in reducing transmission. Screening testing can be administered directly at a school facility (see Feasibility considerations section below), at a central location through the school district, or through referral to community-based testing providers.

- **Moderate (yellow), substantial (orange), and high (red) community transmission**: Students, teachers, and staff participate in regular screening testing to reduce the risk of transmission within the school.
  - Teachers and staff participate in routine screening testing at least once per week. In areas with substantial and high community transmission, twice a week screening testing might be preferable to quickly detect cases among teachers and staff.
  - Students in elementary, middle, and high schools participate in routine screening testing at least once per week. If a confirmed positive case is found, any close contacts are quarantined and tested.
  - Schools might consider testing a random sample of at least 10% of students. For example, a school might randomly select 20% of the students each week for testing out of the entire population of students attending in-person instruction. Alternatively, a school might select one cohort for each grade level each week for testing. Different strategies for random selection can be used based on most adequate fit for a school screening testing strategy.
- **Screening testing for sports**: To facilitate safe participation in sports and reduce transmission in activities that have elevated risk, schools may consider requiring screening testing for participation. Schools can implement testing among student athletes/participants, coaches, and trainers, and any other individuals (such as parent volunteers) who could come into close contact with others during these activities.
  - Sports events, competitions, and activities could include universal screening testing the day of the event or one day before.
  - Low and intermediate risk sports[3] include those that can be conducted outdoors, or indoors with masks. Testing at least once per week is recommended for these sports.
  - High-risk sports[3] include those that cannot be done outdoors or with masks. Testing twice per week in areas of low, moderate, and substantial community transmission is recommended for participation in these sports. High-risk sports should be virtual or canceled in areas of high community transmission.

When considering which tests to use for screening testing, schools or their testing partners should choose tests that can be reliably supplied and that provide results within 24 hours. NAATs are high-sensitivity tests for detecting SARS-CoV-2 nucleic acid. Most NAATs need to be processed in a laboratory with variable time to results (could be 1–3 days), but some NAATs are point-of-care tests with results available in about 15 minutes. Pooled testing—in which samples from multiple people are initially combined—may reduce costs and turn-around times. These may be considered for at least weekly screening testing in areas of moderate (yellow) community transmission.

Antigen tests are generally less sensitive than NAATs, and most can be processed at the point-of-care with results available in about 15 minutes. Antigen test results might need confirmation with a NAAT in certain circumstances, such as a negative test in persons with symptoms or a positive test in persons without symptoms. Schools should work with the health department to develop a confirmation and referral plan before implementing testing. The immediacy of results (test results in 15–30 minutes), modest costs, and feasibility of implementation of antigen tests make them a reasonable option for school-based screening testing. The feasibility and acceptability of tests that use nasal (anterior nares) swabs make these types of tests more readily implemented in school settings. Tests that use saliva specimens might also be acceptable alternatives for younger children, if tests are available and results are returned within 24 hours.

Taking into consideration the potential for limited availability of supplies for screening testing or feasibility of implementing screening testing, schools should consider a prioritization strategy.

- Schools and public health officials might consider prioritizing teachers and staff over students given the increased risk of severe illness among certain adults.

- In selecting among students, schools and public health officials might prioritize high school students, then middle school students, and then elementary school students, reflecting higher infection rates among adolescents compared to younger children.

Reporting test results

Every COVID-19 testing site is required to report to the appropriate state or local health officials all diagnostic and screening tests performed. Schools that use antigen testing must apply for and receive a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver, and report test results to state or local public health departments as mandated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136).

Parents should be asked to report positive cases to schools to facilitate contact tracing and ensure communication and planning in schools. In addition, school administrators should notify staff, teachers, families, and emergency contacts or legal guardians immediately of any case of COVID-19 while maintaining confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Americans with Disabilities Act (ADA), and the Family Educational Rights and Privacy Act (FERPA), and other applicable laws and regulations. Notifications must be accessible for all students, teachers, and staff, including those with disabilities or limited English proficiency (for example, through use of interpreters or translated materials).

Health equity considerations in school-based testing

Public health officials and school administrators should consider placing a higher priority for access to testing in schools that serve populations experiencing a disproportionate burden of COVID-19 cases or severe disease. These might include:

- Schools in communities that have experienced disproportionately high rates of COVID-19 cases relative to population size, which may include communities with moderate or large proportions of racial and ethnic groups, such as American Indian/Alaska Native, Black, and Hispanic persons.
- Schools in geographic areas with limited access to testing due to distance or lack of availability of testing[25].

Ethical considerations for school-based testing

Testing should not be conducted without informed consent from the individual being tested (if an adult) or the individual's parent or guardian (if a minor). Informed consent requires disclosure, understanding, and free choice and is necessary for teachers and staff (who are employees of a school) and students' families to act independently and make choices according to their values, goals, and preferences. Differences in position and authority (i.e., workplace hierarchies), as well as employment and educational status, can affect an individual's ability to make free decisions. CDC provides guidance and information related to consent for COVID-19 testing among employees. These considerations also apply and can be adapted to school-based testing.

Schools should make a communication plan to notify local health officials, staff, and families immediately of any case of COVID-19 while maintaining confidentiality in accordance with the Americans with Disabilities Act (ADA) and Family Educational Rights and Privacy Act (FERPA), the Protection of Pupil Rights Amendment (PPRA), and other applicable laws and regulations. Collaboration with local counsel, education, or public health is recommended to ensure appropriate consent is obtained and maintained and results are retained with appropriate privacy and confidentiality.

Considerations before starting any testing strategy

Before implementing testing in their schools, K–12 school leaders should coordinate with public health officials to ensure there is support for this approach from students, parents, teachers, and staff and to develop a testing plan that has key elements in place, including:

- Dedicated infrastructure and resources to support school-based testing.
- Use of tests that are authorized by FDA for the specific intended use (i.e., screening, pooling), and a mechanism in place for prescriptions/test orders by a licensed healthcare provider.
- CLIA certificate of waiver requirements to perform school-based testing with Emergency Use Agreement-authorized tests.

- A mechanism to report all testing results (both positive and negative) as required by the state or local health department.
- Ways to obtain parental consent for minor students and assent/consent for the students themselves.
- Physical space to conduct testing safely and privately.
- Ability to maintain confidentiality of results and protect student and staff privacy.
- Plans for ensuring access to confirmatory testing when needed through the state or local health department for symptomatic persons who receive a negative test result and asymptomatic persons who receive a positive test result.

If these elements are not in place, schools may consider a referral-based testing strategy in collaboration with public health officials.

Schools should work with local public health officials to decide whether and how to use testing. K–12 schools operated by the federal government (for example, for Department of Defense Education Activity [DoDEA], which operates K–12 schools for DoD Dependents) should collaborate with federal health officials. In addition to state and local laws, school administrators should follow guidance from the Equal Employment Opportunity Commission, and applicable federal laws when offering testing to faculty, staff, and students who are employed by the K–12 school.

Feasibility considerations and challenges of school-based testing

These challenges must be considered carefully and addressed as part of plans for school-based testing developed in collaboration with public health officials.

- In some schools, school-based healthcare professionals (for example, school nurses) can perform COVID-19 viral testing if the school or test site receives a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver . Some school-based healthcare professionals might also be able to perform specimen collection to send to a lab for testing, if trained in specimen collection, without a CLIA certificate. It is important that school-based health care professionals have access to, and training on the proper use of personal protective equipment (PPE). Facilities should be aware of the FDA EUA for antigen tests and the Center for Medicare & Medicaid (CMS's) enforcement discretion regarding the CLIA certificate of waiver when using tests in asymptomatic individuals.
- Not every school system will have the staff, resources, or training (including the CLIA certificate of waiver) to conduct testing. Public health officials should work with schools to help link students and their families, teachers, and staff to other opportunities for testing in their community.
- School-based testing might require a high degree of coordination and information exchange among health departments, schools, and families.
- There might also be legal and regulatory factors to consider with onsite school-based testing regarding who will prescribe the tests, who will administer the tests, how tests will be paid for, and how results will be reported. Such factors include local or state laws defining the services school nurses and other school-based health professionals are permitted to provide, as well as applicable privacy laws.
- The benefits of school-based testing need to be weighed against the costs, inconvenience, and feasibility of such programs to both schools and families.
- Antigen tests usually provide results diagnosing an active SARS-CoV-2 infection faster than NAATs. However, antigen tests have a higher chance of missing an active infection even in symptomatic people, and confirmatory molecular testing might be recommended.

Vaccination for teachers and staff, and in communities as soon as supply allows

Vaccines are an important tool to help stop the COVID-19 pandemic. Teachers and staff hold jobs critical to the continued functioning of society and are at potential occupational risk of exposure to SARS-CoV-2. Vaccinating teachers and staff is one layer of prevention and protection for teachers and staff. Strategies that minimize barriers to access vaccination for teachers and other frontline essential workers, such as vaccine clinics at or close to the place of work, are optimal. To address this important public health priority, the Health and Human Services Secretary issued a Secretarial Directive on March 2, 2021, that directs all COVID-19 vaccination providers administering vaccine purchased by the US government to make vaccines available to those who work in K–12 schools. This means that in addition to existing state and local COVID-19 vaccination sites, teachers and staff in schools across the nation can sign up for an appointment at more than 9,000 pharmacy locations participating in the Federal Retail Pharmacy Program for COVID-19 Vaccination

pharmacy locations participating in the Federal Retail Pharmacy Program for COVID-19 vaccination.

New CDC resources are available to provide information about this directive:

- The COVID-19 Vaccines for Teachers, School Staff, and Childcare Workers web page provides school and childcare staff with the latest information about where and how to book an appointment.
- The COVID-19 Vaccine Toolkit for School Settings and Childcare Programs provides schools and childcare programs with ready-made materials they can use to communicate with staff about COVID-19 vaccination.

School officials and health departments can work together to also support messaging and outreach about vaccination for members of school communities. School communication platforms can facilitate outreach to encourage vaccination of household members of school-age children as they become eligible. This should include outreach in a language that limited English proficient family members of students can understand and in alternate formats as needed to facilitate effective communication for individuals with disabilities.

Implementation of layered prevention strategies will need to continue until we better understand potential transmission among people who received a COVID-19 vaccine and there is more vaccination coverage in the community. In addition, vaccines are not yet approved for use in children under 16 years old. For these reasons, even after teachers and staff are vaccinated, schools need to continue prevention measures for the foreseeable future, including requiring masks in schools and physical distancing.

Definitions

- **School staff** in this document refers to any school employees, contractors, or independent consultants interacting with students or teachers during the course of the school day, including, for example, school administration, bus drivers, school nutrition professionals, school nurses, speech/occupational therapists, custodians, and other school employees.

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Previous Updates

Updates from Previous Content

As of February 26, 2021

- Link added to resource summarizing how to use CDC building ventilation recommendations in schools and child care programs

As of February 24, 2021

- Broken hyperlinks fixed in guidance

Last Updated Mar. 19, 2021

NEA News

Six Ways ESSA Will Improve Assessments

From high-stakes to multiple measures to opt-out, here's how the Every Student Succeeds Act will impact testing.

By: Cindy Long
Published: 03/10/2016

Standardized testing has become so ingrained into her school year that Rebecca Lippy, a fifth-grade teacher at Maryland City Elementary School in Laurel, Maryland, has a hard time imagining how the new Every Student Succeeds Act (ESSA), which has replaced No Child Left Behind, is going to make a difference in her classroom.

"I think right now testing is so institutionalized that it's hard for educators to see a light at the end of the tunnel," says Lippy, a member of the Maryland State Education Association (MSEA).

But she does see a glimmer, and she says she's cautiously optimistic that maybe the new national education law can bring about the positive changes she's heard about from MSEA. These include a reduction in time spent on testing, the ability for teachers to use their own judgment and

expertise to determine what skills their students need to focus on, and an increase in cultural relevancy on the required assessments for students in urban Title I schools like hers (no more questions for city kids about sail boats or babbling brooks!).

But when will all of these changes take place? Gradually, say policy experts, because limited regulations around the law are currently being negotiated at the U.S. Department of Education with key stakeholders, including selected NEA members.

"Even though there is a lot of work ahead, ESSA will be a game-changer, especially if educators get involved in the process in their states and districts now to make sure new assessments are developed with their input and expertise," says Beth Foley, a senior policy analyst at the National Education Association.

Foley recommends that educators reach out to their NEA affiliate and offer to share good practices. They can find ways to get involved in ESSA implementation at the local level, and even help set up monthly meetings with parents and administrators at their schools to make sure ESSA focuses on student growth rather than proficiency.

"Collaboration and partnerships are critical," Foley says.

Here's how ESSA will impact assessments:

1. NO MORE HIGH STAKES

While there will still be tests in reading/language arts and math every year from third to eighth grade and once in high school, ESSA removes

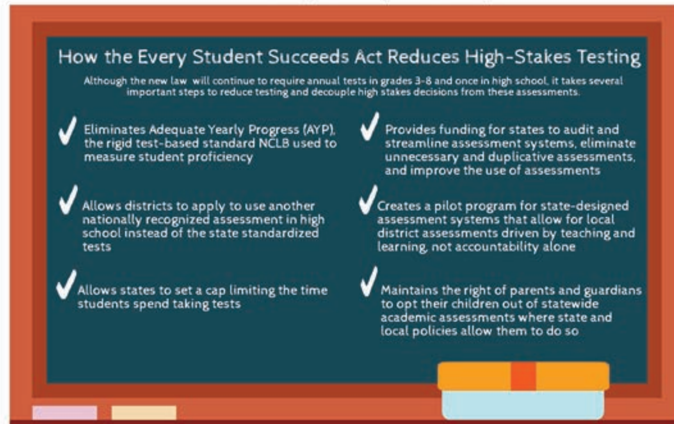
the high stakes that have been attached to standardized testing under NCLB. Under ESSA, schools and teachers can no longer be considered failing just because of low test scores. The goal is to ease the pressures of testing and bring an end to the test prep mania that for years has consumed schools worried they wouldn't meet Annual Yearly Progress (AYP) and face closure, firing of staff, or other sanctions.

2. MORE STATE AND DISTRICT CONTROL

ESSA dramatically reduces the power of the U.S. Department of Education and gives states authority to design and implement the most appropriate assessments.

"In high school, for example, the law will allow the ACT or the SAT to be used for the state assessment," says Foley. "People are happy about that because it means students won't have to take more standardized tests, and it opens doors for students who thought they'd never be college bound because they wouldn't be able to pass the SAT. Now it simply becomes part of the assessment system."

It also gives states the ability to set targets on the amount of time spent on testing.



Click to Enlarge

3. MULTIPLE MEASURES

ESSA also opens the door for other forms of assessment instead of a snapshot test score. Seven states will be able to apply to develop pilots of innovative assessment programs that can use a variety of indicators to show how a student is performing. Multiple measures of proficiency can include projects, portfolios and other locally designed formative assessments that, along with the standardized tests, create a summative score for a student.

Fewer, more forgiving consequences for poor test taking is an aspect of ESSA that Rebecca Lippy in Maryland will eagerly embrace.

"A lot of my students aren't good test takers, and a test score doesn't give an accurate picture of what they can do," she says. "I spend far too much

time teaching them how to take a test, explaining what Part A and Part B is, and so on, and we all know that isn't good instruction."

On the other hand, her students excel when working on projects and she says their level of engagement, motivation and achievement is much more authentic.

"It would make a major difference if I could have input on the tests my students take and how they're learning is assessed," she says.

Assessments should inform instruction, Lippy says, not punish students or educators.

That's exactly what a pilot program in New Hampshire is doing, which is why NEA supports it as a model for other states who may want to be a part of the ESSA pilot. The Performance Assessment of Competency Education (PACE) replaces multiple-choice questions for more meaningful tasks that encourage students to apply what they have learned in sophisticated ways and to use critical thinking and problem solving skills. For example, middle school students could turn in research papers showing they know how to analyze and present information from many sources for English assessments. Fourth-graders might design and cost out a new park for a math assessment.

For the past few years, educators from many New Hampshire districts have been at the table helping to develop assessment systems, ensuring that educators, the people who know their students best, are creating the content. The assessments are intended to be locally designed and controlled and therefore could reduce the amount of student testing while making it more meaningful.

The Every Student Succeeds Act gives states the authority to design and implement better assessments and set targets on the amount of time spent on testing.

"We hear about over-testing because we really have two accountability systems," New Hampshire Department of Education Deputy Commissioner Paul Leather said in a statement. "The state system is required by federal law but may not help us improve teaching and learning. Schools administer their own tests for that. The PACE pilot brings those together and reduces the testing needed."

With these assessments, New Hampshire's system of competency based learning will show mastery and growth more accurately than a single end of year exam or state assessment. In this system, students only move up a grade after they've mastered the defined skills for each grade level.

"We use New Hampshire as an example of how to do assessment right," says Foley. "It represents a better picture of student growth and includes critical educator input."

4. MEASURING GROWTH RATHER THAN PROFICIENCY

In ESSA there is a new focus on demonstrating student growth.

"For example, if you start at 40 and make it to 79, that's huge growth and a student should be recognized for that, even if the cut score is 80" says Foley. "It's getting away from the one day test snapshot and instead will pull together academic indicators that reflect the whole student, and the accomplishments and growth that student has made."

This is especially important for students with disabilities, English-language learners (ELLs), and at-risk students, and it flows into multiple measures to show student growth, which is a more appropriate way to determine how well students are doing and the progress they've made.

"Assessments should be designed to improve and inform instruction rather than determining that a teacher is not doing their job well because some students didn't make the cut score," Foley says. "Growth is what it's important and the new law highlights that."

5. HIGHLIGHTING ACHIEVEMENT GAPS WITHOUT PUNISHING UNDERSERVED STUDENTS

One positive aspect that came out of NCLB was that it highlighted achievement gaps among subgroups of students, and ESSA will continue to do so. There will still be reporting requirements to disaggregate data for five subgroups of students based on race, income, special education, ELLs, and migrant status. Results from the assessments have to be disaggregated by these subgroups and if they aren't performing well, ESSA holds schools accountable and requires that they provide interventions. But gone are the days of closing schools that fail to make AYP in some districts with high populations of at-risk students.

6. OPTING-OUT AND 95 PERCENT PARTICIPATION RATE

Even though NCLB mandated 17 federally required tests, the high stakes attached to them led states and districts to start administering multiple interim benchmark tests to see how well students would do on the federal tests. Then there were more tests if those test results were too low, and so on. Parents finally got fed up with the testing mania and launched an opt-out movement. They kept their kids home on test days to protest the overuse and misuse of test scores, and as a result, many districts in states across the country didn't meet the 95 percent participation requirement and suffered the consequences.

What will happen to the opt-out movement going forward remains to be seen. While ESSA recognizes that families can refuse testing if a state has an opt-out law, like Oregon, it still mandates a 95 percent participation rate. It's up to the states to decide what to do if that rate isn't met, but the law is unclear as to what, if any, those consequences may be.

THE ROAD AHEAD

The focus now is on implementation as states begin to write their state plans, and NEA is encouraging state affiliates to secure a seat at the table and to collaborate, and partner, with state legislators, parents, school boards, superintendents and bargaining teams to make sure implementation goes smoothly and that educators have a strong voice in the process.

"Now is an opportune time for NEA members to truly make their voices heard," says Foley.

This is a first in a series on changes ESSA will bring to public education. You can also find out more about the law at nea.org/essabegins.

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TECHNICAL BRIEF

Comparability analysis of remote and in-person MAP Growth testing in fall 2020

November 2020

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Suggested citation: Kuhfeld, M., Lewis, K, Meyer, P., & Tarasawa, B. (2020). Comparability analysis of remote and in-person MAP Growth testing in fall 2020. NWEA.

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1. Executive Summary

This study examined the psychometric characteristics and indicators of test quality of MAP Growth tests that were administered remotely and in-person in fall 2020. Using test scores from over 535,000 K-8 students in 147 school districts (92 operating fully remotely this fall, 55 offering in-person instruction to all students), this study provides insight into the comparability of remote versus in-school assessment. We found high levels of marginal reliability and test engagement across all grades, as well as consistent trends in test scores for remote and in-person tests for students in grades 3-8. Taken together, these findings increase confidence in the quality of data gathered from remotely administered MAP Growth assessments in grades 3 and up.

Key findings were:

1. Marginal reliability was high (≥0.90) across all grades and subjects across both remote and in-person test administrations.
2. Between-term correlations were high (>0.70) across grades and subjects, regardless of testing modality, with the exception of students in first and second grade in fall 2020.
3. Test engagement and test duration between fall 2019 and fall 2020 were similar between remote and in-person test takers. Students' test engagement remained high both for students who tested remotely and in-person in fall 2020 across grades and subjects.
4. When comparing test duration between fall 2019 and fall 2020, moderately larger increases were observed for students who tested remotely in fall 2020 relative to students who tested in-person.
5. In grades 3 through 8, achievement percentiles stayed the same or dropped from fall 2019 to fall 2020, with trends similar for remote and in-person testers and larger percentile score drops in math than in reading.
6. Students who tested remotely in grades 1 and 2 grade in fall 2020 showed large improvements in their percentile rank since fall 2019; while in-person testers in grades 1 and 2 showed patterns more consistent with older students (percentiles stayed the same or dropped).

2. Introduction

In the NWEA fall 2020 COVID research studies, we present a series of analyses based on MAP® Growth™ data from the fall of the 2020-21 school year as well as prior academic years. A key assumption underlying the interpretation of these data is that the mode of assessment has little to no impact on test scores. However, there are concerns around remotely

administered assessments (e.g., increased distractions, unfamiliar virtual meeting software, potential connectivity challenges, among others) that call into question whether assessments that were administered remotely in fall 2020 can be considered comparable to assessments administered in person.

NWEA launched a program of research to probe the comparability of remote and in-person tests in spring of 2020 when the pandemic first forced schools to close and resort to virtual instruction and assessment. Our initial findings from this research, conducted with a subset of schools that tested remotely in spring 2020, provided encouraging evidence that remote and in-person tests showed comparability in psychometric characteristics as well as student test engagement. [i,ii] Specifically, the spring 2020 comparison found that less than one percent of items showed differential item functioning (DIF) by testing modality (less than the percentage expected by chance alone), and that remote testers showed similar levels of test engagement as students who tested in-person. This research brief updates and builds on those promising findings using fall 2020 data from a large sample of schools across the nation to further investigate the validity and comparability of remote assessments. By triangulating across a range of assessment characteristics including psychometric properties as well as indicators of test engagement, this brief sheds further light on the comparability of remote versus in-person assessment.

Specifically, we explored the following research questions:

1. Did the mode of administration (in-person versus remote) have any impact on the psychometric properties (specifically, marginal reliabilities and test-retest correlations) of the MAP Growth assessments?
2. Were changes in test duration and test engagement between the 2019-20 and 2020-21 school year similar between remote and in-person test takers?
3. Did remote testers in fall 2020 show significantly better test performance relative to in-person testers after adjusting for prior achievement and student/district characteristics? Did remote/in-person differences vary across subjects/grades/racial groups?

The first research question examined a primary concern that the assessment itself functions differently when administered in different assessment modalities. To answer this research question, we examined the reliability of the test when administered remotely or in person. If we can establish test reliability is consistent across remote and in-person settings, we may still expect differences in student performance if aspects of students' testing environment impact their motivation and ability to pay attention during the test. The second research question addressed this concern by examining indicators of student test effort across in-person and remote test settings.

Finally, a remaining question when comparing remote and in-person test performance outcomes is that any differences we may see may not be due to testing modality, but instead attributable to confounding differences between districts that opened in-person versus fully remote. Specifically, it is possible that these districts serve different student bodies, and it is these demographic differences, not testing modality, that drive any differences in performance across settings. We probed this possibility in our third research question by controlling for students' past performance when examining their fall 2020 test scores. Additionally, we examined within-group differences (e.g., comparing White students' performance in remote settings with the

White students who tested in-person this year) controlling for a set of school district characteristics to attempt to better isolate remote/in-person mode effects.

3. Data

The data for this study are from the NWEA anonymized longitudinal student achievement database. School districts use NWEA MAP Growth assessments to monitor elementary and secondary students' achievement and growth throughout the school year, with assessments typically administered in the fall, winter, and spring. We used the reading and math test scores of over 535,000 students, from kindergarten through eighth grade in 2,074 schools from across the United States across three time points: fall 2019, winter 2020, and fall 2020.

3.1. Longitudinal Sample Description

In this study, we followed multiple intact cohorts of students across the 2019-20 and 2020-21 school years. For example, one cohort of students started kindergarten in fall 2019 and entered first grade in fall 2020. The primary advantage of using an intact cohort is that we could compare each student's fall 2020 test performance to his or her own prior test score. A disadvantage is that students may have systematically dropped out of our sample this fall due to the disruptions of COVID-19. For more details on the attrition patterns in the MAP Growth data in fall 2020, see the attrition report.[iii] We separately examined every two-year grade pair from grades K-1 to grades 7-8.

Our sample consisted of a subset of schools and districts who tested with MAP Growth assessments where either (a) the district was operating fully remotely by the time testing occurred this fall, or (b) all students in districts had the option for in-person instruction this fall. NWEA does not currently have a student-level indicator of whether a student tested remotely or in-person in fall 2020. Therefore, we used an indicator of district reopening status (collected by *Education Week*[iv] for over 900 districts in the country) as a best proxy for the likelihood testing was administered remotely or in-person in fall 2020 (districts that had a hybrid reopening plan were excluded). Students who attended schools with remote learning only and no in-person instruction available were defined as “Remote testers.” Students who attended schools with full-time, in-person instruction available for all students were defined as “In-person testers.” However, it is likely that this classification is imperfect as some students in districts in which in-person instruction was available for all students still may have opted to learn and test remotely this fall. NWEA is developing an indicator to more precisely capture whether a test was administered remotely or in-person which will make it possible to compare data quality across testing modalities more systematically in future research.

3.2. Sample Descriptive Statistics

In total, our sample contained 535,000 students from 147 unique districts (55 remote, 92 in-person). Descriptive statistics of the sample suggested in-person and remote districts were demographically and geographically different from each other (see Table 1). Eighty-four percent of school districts in our sample that opened remotely were in urban or suburban areas, while only 31% of in-person districts were in urban/suburban areas. The average enrollment in

districts that opened remotely in fall 2020 was far larger than the districts that opened in-person. Overall, the sample size per grade ranged from 40,000 to 90,000 students, and the majority of students in the districts that opened in-person were White, while the students in the remote only districts were more racially diverse (see Table 2).

3.3. Data Quality Measures

Measures of achievement. We used student test scores from NWEA MAP Growth reading and math assessments in this study. MAP Growth is a computer adaptive test—which means the level of precision is similar for students across the achievement distribution, even for students above or below grade level —and is vertically scaled to allow for the estimation of gains across time. Test scores are reported on the RIT (Rasch unIT) scale, which is a linear transformation of the logit scale units from the Rasch item response theory model. In this study, we used both students' RIT scores and percentile scores calculated using the NWEA 2020 MAP Growth norms.[v]

Measures of test effort. We presume that remote testing takes place in a less controlled environment than in schools, given potential additional distractions and concerns about students receiving assistance from family or use of outside resources on the assessment. The potential for a qualitatively different testing experience in remote settings compared to in school raises important questions about the quality of data from remote testing. Given the additional challenges of testing in a home environment, an important indicator of data quality is whether students were able to stay engaged during a test. Test disengagement, specifically rapid-guessing—when a student answers a test question so quickly that they could not have understood its content and provided an effortful response—poses a substantial threat to test validity.[vi]

While the remote testing environment differs from in-school testing, the MAP Growth assessment includes features intended to identify rapid-guessing behaviors and provide information to students and proctors to encourage students to re-engage with the assessment. When MAP Growth assessments are administered in schools, a proctor in the testing room gives students a password and instructions on how to access the test, answers student questions during testing, and monitors student progress on a computer that displays each student's progress. In remote testing, proctors are not physically present with students and cannot visually monitor the students' testing environments. Instead, proctors and students communicated during remote testing using a variety of methods, including text messages, phone conversations, and online video conferencing software. When video conferencing was used, the proctors had a webcam view of all students being testing but could not actively monitor a student's test-taking environment. Regardless of where the assessment is administered, MAP Growth uses an "auto-pause" feature to identify rapid-guessing and address test-taking disengagement in real-time: after a pre-specified number of rapid guesses, the test is automatically paused, and a message is displayed on the student's computer screen informing them that they are rushing through the test and asking them to slow down. The test proctor also receives a notification of the auto-pause and must enter a passcode to resume the student's test, presumably after encouraging the student to answer questions effortfully. If rapid-guessing continues, the auto-pause feature may engage up to two additional times during the assessment.

Prior NWEA comparisons of test engagement for students who tested remotely versus in person provided encouraging evidence that test engagement was similar in both remote and in-school test administrations in spring 2020.[ii] We expanded on this initial promising finding with more recent data by examining whether student engagement on MAP Growth assessments differs in remote testing on two measures of student test taking engagement. First, we examined trends in students' Response Time Effort (RTE), which indicates the proportion of responses that were solution behaviors rather than rapid guesses.[vii] Second, we looked at changes in overall test duration (measured as the number of minutes elapsed between the start and end of the test, excluding any pauses) between fall 2019 and fall 2020.

4. Methods

4.1. Psychometric Properties

We calculated the marginal reliability (for more information on the calculation of reliability, see NWEA, 2019[viii]) and test-retest reliability. We calculated these metrics for three testing terms (fall 2019, winter 2020, and fall 2020). We specifically included two pre-COVID-19 terms to establish a baseline against which to evaluate fall 2020 metrics.

4.2. Test Effort

We examined whether changes in student test effort between fall 2019 and fall 2020 varied dependent on whether students tested remotely or in-person. Specifically, we calculated RTE and average test duration by grade, term, subject, and plotted trends within each group separately by fall 2020 testing modality.

4.3. Test Performance

As noted above, simple between-group comparisons of test performance for in-person testers and remote testers may be uninformative or even misleading because of potentially confounding differences between districts that opened for in-person instruction and those that remained remote. To address this, we examined within-student changes in percentile rank between fall 2019 and fall 2020 separately by grade, subject, and fall 2020 testing modality. Within-student comparisons allow us to account for potential baseline differences in achievement between students in districts that opened remotely or in-person this fall. If testing remotely is associated with systematic changes in student achievement, we would expect to see different patterns in shifts in percentile rank over time between the two testing modalities.

In addition, to further rule out the explanation that differences observed between remote and in-person test scores in fall 2020 could be due to pre-existing differences between students in the two sets of districts, we ran a series of regression models that tested for differences in scores by testing modality while controlling for students' prior achievement, student demographic characteristics, and district characteristics. Specifically, we regressed the fall 2020 RIT scores on the fall 2019 RIT scores, an indicator for testing modality (where in-person is the reference group) in fall 2020, and a set of student- (indicators of race/ethnicity) and district-level covariates (district SES, percentage of English Learner (EL) students, percentage of special education students, and urbanity of district). We also thought it possible that the impact of testing modality

could differ across student groups, if, for instance, some student groups are more likely than others to experience home environments that are less conducive to ideal testing conditions. To allow for potential differences across student groups in the impact of testing remotely, we included a set of interaction terms between student race/ethnicity and attending school remotely in fall 2020. In this model, we estimated cluster robust standard errors to account for nesting of students in districts.

$$\begin{aligned} \text{Fall20score}_i = {} & \beta_0 + \beta_1 \text{Fall19score}_i + \beta_2 \text{RemoteF20}_i + \beta_3 (\text{Fall19score}_i * \text{RemoteF20}_i) + \\ & \beta_4 \text{Black}_i + \beta_5 \text{Asian}_i + \beta_6 \text{Hispanic}_i + \beta_7 \text{OtherRace}_i + \\ & \beta_8 (\text{Black}_i * \text{RemoteF20}_i) + \beta_9 (\text{Asian}_i * \text{RemoteF20}_i) + \\ & \beta_{10} (\text{Hispanic}_i * \text{RemoteF20}_i) + \beta_{11} (\text{OtherRace}_i * \text{RemoteF20}_i) + \cdots + e_i. \end{aligned}$$

From this model, we estimated within-group differences in fall 2020 RIT score between remote testers and in-person testers (controlling for prior test score and district demographic characteristics) separately for each racial/ethnic group:

White Gap: $\hat{\beta}_2$
Black Gap: $\hat{\beta}_2 + \hat{\beta}_8$
Asian Gap: $\hat{\beta}_2 + \hat{\beta}_9$
Hispanic Gap: $\hat{\beta}_2 + \hat{\beta}_{10}$

5. Results

5.1. Psychometric Properties

We examined whether the assessment modality was associated with the reliability and across-time stability of students' test scores. Marginal reliability was high (≥0.90) across all grades and subjects across both remote and in-person test administrations (see Table 3). Between-term correlations were generally high (>0.70) across grades, subjects, and reopening status (see Table 4) with only few exceptions. For students in first and second grades who tested remotely in fall 2020, we saw lower test-retest correlations between pre-COVID-19 test scores and fall 2020 test scores; the same was not true of first- and second-grade students who tested in person. This suggests that test scores were less consistent from one testing period to the next for the youngest students who tested remotely, but not those who tested in person. Taken together, consistently high marginal reliabilities and test-retest correlations suggest that mode of administration appeared to have no adverse effects on the psychometric properties of MAP Growth, though differences were observed across test administration mode for students in the lowest grades.

5.2. Test Effort

Next, we examined if changes in test engagement and test duration between fall 2019 and fall 2020 were similar between remote and in-person test takers. Students' average RTE remained high across grades both for students who tested remotely and in-person in fall 2020 across grades (see Figure 1), indicating that testing remotely was not tied to a large decrease in test engagement this fall. Moderately larger increases in test score duration were observed for students who tested remotely in fall 2020 relative to students who tested in person, particularly

in the younger grades (see Figure 2). Although not displayed in Figures 1 and 2, average RTE and test duration in math were consistent with those depicted for reading.

5.3. Test Performance

We first conducted a descriptive analysis to examine whether performance shifted over time in different ways for remote testers compared to in-person testers. To do this, we plotted changes in students' median achievement percentiles from fall 2019 to fall 2020 separately by testing modality. As shown in Figures 3 (math) and 4 (reading), we found different patterns depending on grade level. In grades 3 through 8, test score percentiles stayed the same or dropped from fall 2019 to fall 2020, and these trends were similar for remote and in-person testers. Consistent with our research on learning loss across the COVID-19 period, we observe percentile rank drops were larger in math than in reading.[ix] However, in the early grades, we saw that trends in achievement shifts between fall 2019 and fall 2020 looked very different between remote testers and in-person testers. Specifically, students who tested remotely in first and second grade in fall 2020 showed large increases in their percentile rank since fall 2019; in contrast, in-person first- and second-grade testers showed patterns more consistent with older students (percentiles stayed the same or dropped). These results suggest that the remote testing experience is consistent with in-person testing for students in grade 3 and up but may qualitatively differ for the youngest students.

In addition to the descriptive analyses, we used regression models to explore if remote testers in fall 2020 showed significantly different test performance in fall 2020 relative to in-person testers after adjusting for prior achievement and student/district characteristics (see Table 5 for regression coefficients). In math, students who tested remotely typically scored higher than students who tested in person as indicated by a significant regression coefficient for our indicator of testing modality across grades. Although statistically significant, the remote testing advantage in math was slight (roughly 1 to 2 RIT points) for students in grade 3 and up and may have little practical significance. However, consistent with the findings from our descriptive analyses, remote testing advantages were especially notable for students in grades 1 and 2 in fall 2020, for whom the differences between in-person and remote testers were sizable in both math and reading (roughly 5 RIT points or more, which corresponds to over 0.25 SD). There was little evidence of a remote testing advantage in reading for older students who typically scored similarly or slightly lower compared with students who tested in person.

Finally, we also examined whether fall 2020 scores for remote versus in-person testers were different across subjects, grades, and racial/ethnic groups to understand whether students were differentially impacted by remote testing. The results of these within-group comparisons are plotted in Figure 5 (math) and Figure 6 (reading). We found that across grade levels, and relative to their same-race counterparts, Asian students showed the largest advantage from remote testing. Hispanic students were the most likely to perform lower on average when testing remotely, compared to Hispanic students who tested in person. This pattern was particularly evident in reading, though results varied somewhat by grade level.

6. Conclusion

Our analyses of the psychometric properties of the MAP Growth assessments provided general support for the comparability of scores from the two modes of testing for students in grade 3 and up. The results also showed similar test taking engagement, as measured by RTE, for remote and in-person assessments. This is encouraging, since rapid-guessing test disengagement poses a validity threat, and it seemed plausible that students could be less engaged without a proctor in the room with them. The high reliability for in-person and remote assessments, high test-retest correlations, and the similar trends in test scores for remote and in-person tests for students in grades 3-8 likewise increase confidence in the quality of data from remote assessments.

However, our results also raise questions that require additional exploration related to remote test data for students in K-2. In these grades, we found marginal reliability was high regardless of testing modality and test disengagement was low. We did however observe significantly lower test-retest correlations between in-person pre-COVID-19 test scores and scores from tests administered remotely in fall 2020 for students in these grades. We also observed longer average test durations and large increases in achievement percentiles for K-2 remote testers (but not in-person testers in these grades). Taken together, these findings suggest that remote testing may be a qualitatively different experience for the youngest students. Our data cannot speak to why we see different results for students in these grades and further research is needed to better understand these differences. Additional guidance and support may be needed to help schools and families establish testing conditions at home that are structured to be as similar as possible to in-person testing conditions, most especially for students in these earlier grades.

Finally, these analyses identified moderate differences in student performance between remote and in-person test administrations across race/ethnicity subgroups. Specifically, test scores of students from certain racial/ethnic groups were higher in remote testing conditions in comparison to their same-race peers who tested in-person, particularly in the earliest grades. Additional research can help us understand to what extent differences in home learning environments and economic and public health factors may be contributing to these differences across student groups.

In summary, the findings of these analyses strengthen confidence in the quality of the data from remote tests across most grades, with largely consistent findings in grade 3 and up across testing modalities. However, our results also indicate that caution is warranted when interpreting the test results for certain subsets of students who tested remotely, especially students in the earlier grades, and underscores the need for additional steps to be taken to ensure consistency in administration procedures for tests administered remotely in subsequent testing terms.

Table 1. Comparison of School Districts with Known Fall 2020 Reopening Plans That Tested in Fall 2019 and Fall 2020

	Full in-person reopening available for all students	Remote learning only
Average socioeconomic status (Standardized)	0.29	0.14
Average enrollment	7,102	28,351
Proportion urban	0.18	0.41
Proportion suburban	0.13	0.43
Proportion town	0.35	0.04
Proportion rural	0.35	0.11
Average % households with BA degree	0.24	0.34
Average % SPED	0.14	0.13
Average % ELL	0.04	0.12
Average % households in poverty	0.16	0.20
Average % SNAP receipt	0.10	0.11
Number of Districts	55	92

Note: SPED=Special Education, BA=bachelor's, ELL=English Language Learner. District demographic data comes from the Stanford Education Data Archive (SEDA).

Table 2. Sample Demographic Characteristics by Grade for Overall Sample and Broken Down by Fall 2020 Reopening Status

							Sample Size		
Grade	Male	White	Black	Other Race	Hispanic	Asian	Students	Schools	Districts
Overall Sample									
1	0.51	0.37	0.18	0.11	0.31	0.05	44,711	972	100
2	0.51	0.39	0.18	0.11	0.30	0.05	68,546	1,160	114
3	0.51	0.38	0.17	0.11	0.32	0.05	82,268	1,397	126
4	0.51	0.38	0.17	0.11	0.31	0.05	87,324	1,416	125
5	0.51	0.37	0.18	0.11	0.31	0.05	88,310	1,404	127
6	0.51	0.41	0.18	0.11	0.26	0.05	55,267	590	114
7	0.51	0.41	0.18	0.10	0.27	0.05	60,578	495	111
8	0.50	0.40	0.19	0.11	0.30	0.04	48,255	488	114
Sample of Districts that Opened Remotely in Fall 2020									
1	0.51	0.28	0.21	0.11	0.36	0.06	32,379	695	52
2	0.51	0.32	0.20	0.11	0.35	0.06	49,740	831	62
3	0.51	0.31	0.19	0.11	0.37	0.06	61,177	1,023	73
4	0.51	0.31	0.19	0.11	0.36	0.05	63,783	1,027	71
5	0.51	0.31	0.20	0.11	0.36	0.06	65,631	1,030	74
6	0.51	0.35	0.21	0.11	0.29	0.06	40,425	440	66
7	0.50	0.36	0.21	0.10	0.29	0.06	45,806	375	65
8	0.50	0.33	0.21	0.11	0.34	0.05	36,347	377	70
Sample of Districts that Opened In-Person in Fall 2020									
1	0.51	0.62	0.09	0.11	0.16	0.02	12,332	277	48
2	0.51	0.59	0.12	0.11	0.16	0.02	18,806	329	52
3	0.51	0.58	0.13	0.10	0.16	0.02	21,091	374	53
4	0.51	0.58	0.12	0.11	0.18	0.02	23,541	389	54
5	0.50	0.56	0.12	0.10	0.19	0.03	22,679	374	53
6	0.51	0.56	0.11	0.11	0.19	0.03	14,842	150	48
7	0.51	0.57	0.10	0.10	0.21	0.03	14,772	120	46
8	0.51	0.58	0.10	0.11	0.19	0.02	11,908	111	44

Note: Grade refers to the grade each cohort of students was enrolled in during fall 2020.

Table 3. MAP Growth Test Marginal Reliability by Grade, Subject, and Term

Grade	In-person testers			Remote testers		
	F19	W20	F20	F19	W20	F20
			Math			
1	0.90	0.92	0.94	0.91	0.93	0.96
2	0.93	0.93	0.95	0.94	0.94	0.96
3	0.95	0.95	0.95	0.95	0.95	0.96
4	0.95	0.94	0.95	0.95	0.95	0.96
5	0.95	0.95	0.96	0.96	0.96	0.96
6	0.96	0.96	0.95	0.96	0.96	0.96
7	0.96	0.96	0.96	0.96	0.96	0.97
8	0.97	0.97	0.97	0.97	0.97	0.97
			Reading			
1	0.87	0.91	0.94	0.88	0.92	0.96
2	0.93	0.94	0.96	0.94	0.95	0.97
3	0.96	0.96	0.96	0.96	0.96	0.96
4	0.96	0.95	0.96	0.96	0.96	0.96
5	0.95	0.95	0.95	0.96	0.96	0.96
6	0.95	0.95	0.95	0.96	0.95	0.96
7	0.95	0.95	0.95	0.96	0.95	0.96
8	0.95	0.95	0.95	0.96	0.96	0.96

Note: Grade refers to the grade each cohort of students was enrolled in during fall 2020.
F19=Fall 2019 test scores. W20=Winter 2020 test scores. F20=Fall 2020 test scores.
For each cohort, the F19 and W20 results refer to the prior grade while F20 corresponds to the grade shown in each row.

Table 4. Test-Retest Reliability by Grade, Subject, and Fall 2020 Reopening Status

Grade	In-person testers			Remote testers		
	F19-W20	F19-F20	W20-F20	F19-W20	F19-F20	W20-F20
			Math			
1	0.77	0.67	0.72	0.77	0.42	0.44
2	0.84	0.71	0.73	0.85	0.53	0.55
3	0.86	0.78	0.80	0.87	0.69	0.71
4	0.87	0.83	0.84	0.89	0.79	0.80
5	0.89	0.86	0.88	0.91	0.85	0.85
6	0.91	0.87	0.88	0.92	0.85	0.86
7	0.90	0.88	0.90	0.92	0.87	0.88
8	0.92	0.90	0.91	0.93	0.89	0.89
			Reading			
1	0.66	0.59	0.67	0.66	0.40	0.45
2	0.82	0.68	0.72	0.82	0.54	0.58
3	0.86	0.79	0.82	0.86	0.73	0.76
4	0.86	0.82	0.83	0.87	0.79	0.80
5	0.86	0.83	0.84	0.88	0.82	0.83
6	0.86	0.83	0.84	0.88	0.83	0.83
7	0.87	0.84	0.85	0.88	0.83	0.84
8	0.87	0.85	0.85	0.88	0.83	0.84

Note: Grade refers to the grade each cohort of students was enrolled in during fall 2020. F19=Fall 2019 test scores. W20=Winter 2020 test scores. F20=Fall 2020 test scores.

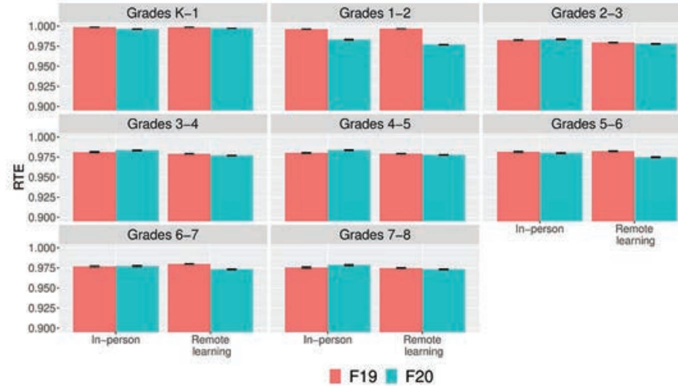
Table 5. Results from Regression Model Predicting Fall 2020 Test Scores

	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6	Grade 7	Grade 8
	Math							
Intercept	165.23 (0.65)***	175.97 (0.49)***	189.76 (0.32)***	199.16 (0.26)***	210.75 (0.24)***	212.87 (0.25)***	221.44 (0.26)***	226.10 (0.31)***
Fall 2019 RIT Score	0.85 (0.01)***	0.80 (0.01)***	0.75 (0.01)***	0.86 (0.00)***	0.94 (0.00)***	0.83 (0.00)***	0.93 (0.01)***	0.90 (0.01)***
Tested Remotely in Fall 2020	6.83 (0.26)***	4.80 (0.18)***	2.73 (0.13)***	1.76 (0.11)***	1.27 (0.11)***	1.32 (0.12)***	1.17 (0.12)***	1.36 (0.15)***
Black	-1.23 (0.47)**	-1.82 (0.29)***	-1.98 (0.21)***	-1.72 (0.18)***	-1.03 (0.18)***	-0.47 (0.22)*	-0.90 (0.24)***	-1.18 (0.27)***
Hispanic	-1.16 (0.38)**	0.19 (0.27)	-1.32 (0.20)***	-0.63 (0.16)***	-0.38 (0.15)*	-0.91 (0.18)***	-1.19 (0.19)***	-1.19 (0.23)***
Asian	3.44 (1.03)***	3.18 (0.63)***	1.88 (0.45)***	1.81 (0.36)***	1.90 (0.33)***	1.51 (0.40)***	2.12 (0.42)***	1.17 (0.55)*
Other Race	-0.31 (0.44)	-0.80 (0.32)*	-0.67 (0.24)**	-0.79 (0.20)***	-0.53 (0.19)**	-0.94 (0.21)***	-0.66 (0.24)**	-0.55 (0.28)*
Fall 2019 RIT by Tested Remotely	-0.24 (0.02)***	-0.20 (0.01)***	-0.07 (0.01)***	-0.05 (0.01)***	-0.04 (0.01)***	-0.01 (0.01)**	0.01 (0.01)*	0.05 (0.01)***
Black by Tested Remotely	0.67 (0.52)	0.58 (0.34)	-0.19 (0.25)	-0.16 (0.21)	-1.02 (0.20)***	-1.12 (0.25)***	-0.38 (0.26)	0.46 (0.31)
Hispanic by Tested Remotely	0.58 (0.44)	-0.50 (0.30)	-0.65 (0.23)**	-1.12 (0.18)***	-1.55 (0.17)***	-1.29 (0.21)***	-0.66 (0.22)**	0.28 (0.26)
Asian by Tested Remotely	4.30 (1.08)***	4.23 (0.67)***	2.30 (0.49)***	1.51 (0.40)***	1.28 (0.36)***	2.35 (0.44)***	1.96 (0.45)***	2.49 (0.60)***
Other Race by Tested Remotely	0.69 (0.55)	1.52 (0.41)***	0.71 (0.30)*	0.45 (0.25)	-0.30 (0.24)	0.35 (0.27)	0.13 (0.29)	-0.37 (0.36)
District Average SES	-0.11 (0.14)	0.58 (0.10)***	0.81 (0.07)***	0.65 (0.06)***	0.28 (0.06)***	0.89 (0.06)***	0.25 (0.06)***	0.31 (0.07)***
% SPED in District	-25.77 (4.24)***	-8.04 (3.25)*	-10.85 (2.13)***	-3.05 (1.78)	-11.43 (1.70)***	8.75 (1.71)***	2.01 (1.74)	-0.65 (2.03)
% ELL in District	-3.83 (1.18)**	-2.83 (0.89)**	-5.94 (0.44)***	-4.15 (0.36)***	-3.91 (0.34)***	-1.26 (0.37)***	-1.61 (0.37)***	-2.15 (0.40)***
Suburb	-0.20 (0.17)	-1.49 (0.11)***	-1.32 (0.08)***	-0.52 (0.07)***	-1.13 (0.06)***	-0.35 (0.09)***	-1.46 (0.09)***	-2.28 (0.11)***
Town	-3.16 (0.29)***	-2.33 (0.23)***	-2.53 (0.17)***	-1.51 (0.14)***	-1.60 (0.14)***	-0.30 (0.14)*	-1.37 (0.14)***	-1.34 (0.16)***
Rural	-0.18 (0.28)	-1.39 (0.21)***	-1.88 (0.15)***	-0.94 (0.13)***	-0.91 (0.12)***	-0.19 (0.14)	-0.58 (0.14)***	-1.39 (0.16)***
	Reading							
Intercept	158.20 (0.64)***	173.68 (0.58)***	189.04 (0.39)***	198.99 (0.30)***	206.21 (0.28)***	212.01 (0.30)***	216.24 (0.30)***	220.38 (0.30)***
Fall 2019 RIT Score	0.86 (0.02)***	0.93 (0.01)***	0.82 (0.01)***	0.80 (0.00)***	0.81 (0.00)***	0.80 (0.01)***	0.83 (0.01)***	0.83 (0.01)***
Tested Remotely in Fall 2020	6.05 (0.26)***	4.97 (0.21)***	2.20 (0.16)***	0.83 (0.13)***	0.45 (0.12)***	-0.23 (0.14)	-0.14 (0.14)	-0.37 (0.15)*
Black	-1.77 (0.46)***	-1.04 (0.35)**	-1.69 (0.25)***	-2.25 (0.21)***	-1.61 (0.20)***	-1.34 (0.24)***	-1.23 (0.28)***	-1.59 (0.28)***
Hispanic	-2.56 (0.40)***	-0.84 (0.32)**	-1.69 (0.24)***	-1.13 (0.18)***	-0.83 (0.17)***	-1.25 (0.21)***	-1.59 (0.22)***	-1.17 (0.22)***
Asian	2.45 (1.08)*	3.04 (0.75)***	0.18 (0.55)	0.40 (0.42)	0.81 (0.37)*	1.77 (0.47)***	0.94 (0.47)*	1.00 (0.47)*
Other Race	-0.94 (0.43)*	-0.86 (0.38)*	-0.77 (0.29)**	-0.64 (0.24)**	-0.93 (0.22)***	-1.12 (0.24)***	-0.36 (0.27)	-0.22 (0.28)
Fall 2019 RIT by Tested Remotely	-0.21 (0.02)***	-0.21 (0.01)***	-0.08 (0.01)***	-0.03 (0.01)***	0.00 (0.00)	0.01 (0.01)*	0.02 (0.01)**	0.04 (0.01)***
Black by Tested Remotely	0.57 (0.51)	0.11 (0.40)	-0.69 (0.29)*	-0.53 (0.24)*	-0.74 (0.23)**	-0.83 (0.28)**	-0.88 (0.31)**	0.27 (0.31)
Hispanic by Tested Remotely	-0.05 (0.45)	-0.54 (0.37)	-1.43 (0.27)***	-2.03 (0.21)***	-1.92 (0.20)***	-1.27 (0.25)***	-0.96 (0.25)***	0.01 (0.25)
Asian by Tested Remotely	3.55 (1.14)**	3.58 (0.81)***	1.27 (0.59)*	0.30 (0.47)	0.34 (0.41)	-0.07 (0.52)	0.75 (0.50)	1.57 (0.51)**
Other Race by Tested Remotely	1.67 (0.53)**	2.17 (0.47)***	0.66 (0.35)	-0.28 (0.30)	0.23 (0.27)	0.51 (0.32)	-0.78 (0.33)*	-0.36 (0.35)
District Average SES	0.81 (0.12)***	0.81 (0.10)***	1.26 (0.07)***	0.86 (0.07)***	0.80 (0.06)***	0.62 (0.07)***	0.40 (0.06)***	0.49 (0.07)***
% SPED in District	-13.28 (4.08)**	-18.51 (3.76)***	-4.78 (2.53)	-3.62 (2.04)	-1.48 (1.94)	4.78 (2.00)*	5.15 (1.94)**	-0.41 (1.89)
% ELL in District	-0.39 (1.09)	0.95 (1.01)	-3.44 (0.52)***	-2.93 (0.42)***	-2.37 (0.38)***	-1.33 (0.42)**	0.61 (0.42)	-0.95 (0.42)*
Suburb	2.59 (0.17)***	1.43 (0.14)***	-0.51 (0.10)***	-0.06 (0.08)	-0.58 (0.07)***	-0.24 (0.10)*	-0.10 (0.09)	-0.52 (0.10)***
Town	-1.94 (0.28)***	-1.29 (0.27)***	-2.28 (0.19)***	-1.32 (0.17)***	-0.62 (0.16)***	-0.42 (0.16)*	-0.35 (0.17)*	-0.28 (0.17)
Rural	1.73 (0.28)***	0.20 (0.24)	-1.00 (0.18)***	-0.50 (0.15)**	-0.50 (0.14)***	0.09 (0.16)	0.33 (0.16)*	-0.07 (0.16)

Note: Grade refers to the grade each cohort of students was enrolled in during fall 2020.

Comparability analysis of remote and in-person MAP Growth testing in fall 2020 Page 13

Figure 1: Trends in Average Response Time Effort (RTE) in Reading by Grade and Fall 2020 Reopening Status



Comparability analysis of remote and in-person MAP Growth testing in fall 2020 Page 14

Figure 2: Trends in Average Test Duration in Reading by Grade and Fall 2020 Reopening Status

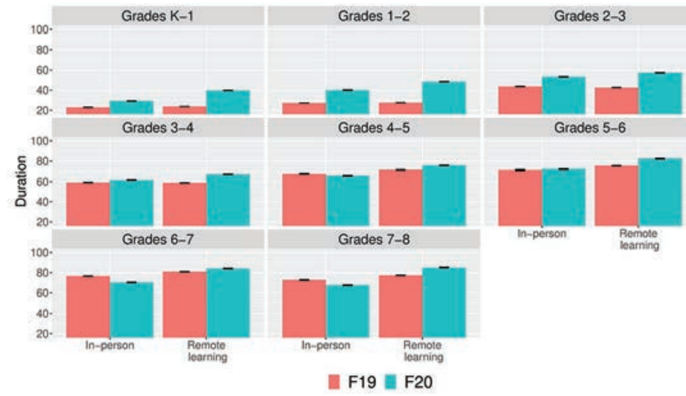


Figure 3: Average Changes in Test Score Percentiles Between Fall 2019 and Fall 2020 in Math by Grade and Fall 2020 Reopening Status

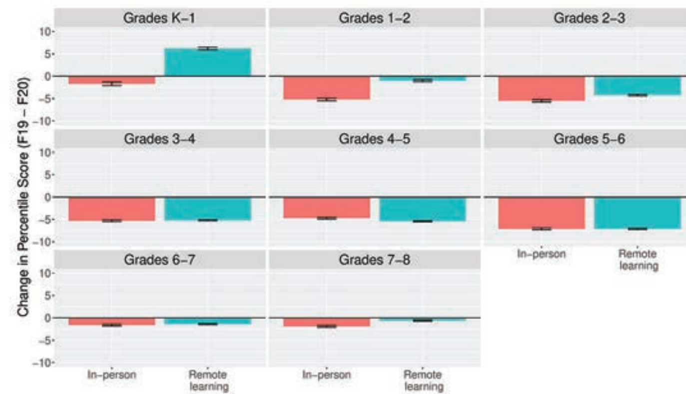


Figure 4: Average Changes in Test Score Percentiles Between Fall 2019 and Fall 2020 in Reading by Grade and Fall 2020 Reopening Status

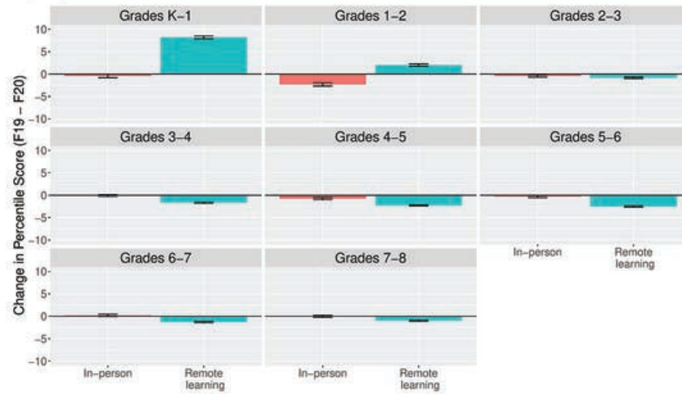
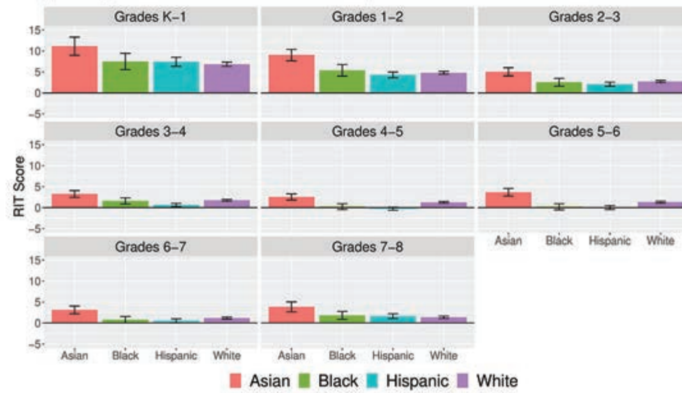
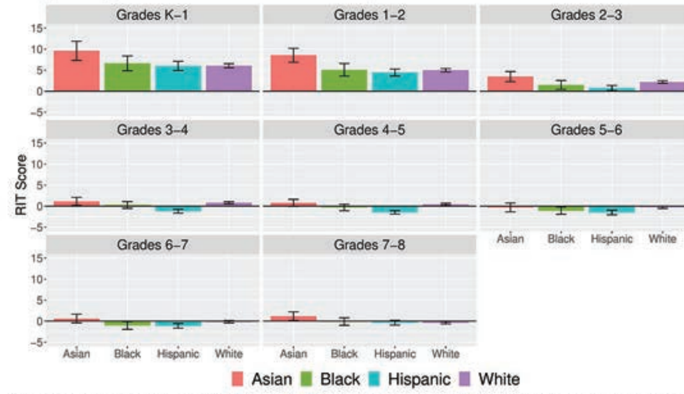


Figure 5: Average Difference in Fall 2020 Math RIT Scores Between Remote and In-Person Testers by Grade and Racial/Ethnic Groups (Controlling for Prior Achievement and District Characteristics)



Note: Positive values indicate remote testers scored better on average than their same-race peers within in-person settings, while negative values indicate in-person testers scored better on average in fall 2020. Reported estimates were calculated based on the Remote variable and the Remote by race/ethnicity interaction terms.

Figure 6: Average Difference in Fall 2020 Reading RIT Scores Between Remote and In-Person Testers by Grade and Racial/Ethnic Groups (Controlling for Prior Achievement and District Characteristics)



Note: Positive values indicate remote testers scored better on average than their same-race peers in in-person settings, while negative values indicate in-person testers scored better on average in fall 2020. Reported estimates were calculated based on the Remote variable and the remote by race/ethnicity interaction terms.

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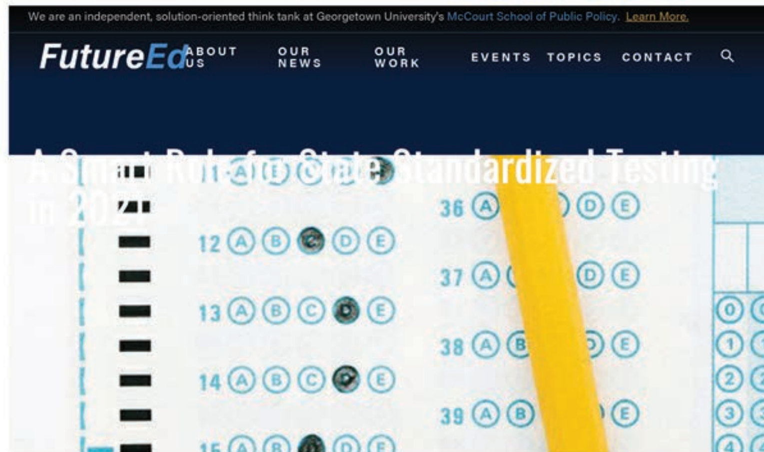


Sound And Fury

June 14, 2021

Andrew Ho
Research Advisor

Put yourself in the shoes of a state or school district education leader about to receive a share of hundreds of billions of dollars from the American Rescue Act, the largest infusion of federal education funding in history. Which schools and grades could use the most support? As you chart a path to allocate these funds before they expire in 2024, how can you and your constituents monitor educational progress?

State standardized tests are ideally suited for this purpose. Yet many state and district leaders are asking for waivers from testing this spring, arguing that testing is unnecessary, infeasible, and even inhumane.

I can see why. While tests could diagnose needs and direct effective interventions, 20-plus years of education policy have cast testing as a tool for unforgiving accountability. Stories of failure dominate stories of improvement. Achievement gap rhetoric can reinforce racist and classist ideas that low-scoring students have irrevocable deficits. State tests have lost the support of many students, parents, teachers, and school leaders.

The lingering mistrust and doubt are understandable. Without specific answers to the questions of how states and districts will use test scores to target support, education professionals may assume that testing is just a ploy to get back to the same old accountability blame-game, to set a new baseline for the next value-added model.

It is an unfortunate coincidence that this oft-deserved backlash is culminating in a political movement to waive state tests just when these tests could help policymakers direct federal Covid relief aid effectively. And this could be accomplished without forcing children to take standardized tests or holding schools accountable for test results.

Testing is necessary, feasible, and, if flexible, humane. Especially if it is part of an "educational census" that brings "all data on deck"—information on students' academic

achievement, but also their physical and emotional health, attendance records, and other equity indicators—to help ensure that students who need the most help get it. State tests have three particular strengths that make them valuable this spring above and beyond classroom and district assessments that provide timely feedback: comparability, alignment, and authority.

[Read More: Blueprint for Testing: How Schools Should Assess Students During the Covid Crisis]

State standardized tests have strong quality controls that enable experts to compare student results across schools and school districts and over time. Comparability over time enables leaders to target resources not only to schools, grades, and subpopulations that needed support in 2019, but also those who now need even more support in the wake of the pandemic.

Second, state tests are designed to measure consensus content standards more directly than district and local alternatives. Although some states have suggested that district tests will suffice, there is not sufficient evidence to support "equating" of district and state tests.

Third, state tests have credible performance standards, selected by consensus among teachers and subject matter experts in each state. These standards can highlight disparities and inequities with the greatest authority. Together, the comparability, alignment, and authority of state tests enable us to answer a critical question that other tests cannot: Where have our needs grown greatest?

But states must change their business-as-usual score reporting. Failure to do so will cripple the validity of the results by conflating changes in student populations with changes in student proficiency. A school that has an out-migration of previously high-scoring students will look like it needs disproportionate assistance when it does not. A school that has an out-migration of low-scoring students will look like it does not need assistance when it desperately does.

This year, unlike a typical year when almost all students are in school, we must pay attention to both students who are tested, and those who are not. This can be accomplished by considering three metrics instead of one: a "fair trend," an "equity check," and a "match rate." Like a blood pressure reading that provides two useful numbers, these multiple metrics provide a necessarily complete assessment of school needs while accommodating absences, departures, and students who opt out.

The "fair trend" captures the progress of 2021 test takers by comparing their results to their own past scores. The "equity check" describes the scores of students who are not tested in 2021 by looking at their past scores. The "match rate" describes the relative weight of the two. If there is no testing this spring, educators are essentially left with only an "equity check"

A Spring 2021 State Testing Checklist

1. Offer tests this spring to enable comparability to the spring of 2019.

2. Bring "all data on deck" for a complete "educational census."

3. Accept the USDOE invitation to waive school accountability.

4. Commit to not using 2020-21 data for future accountability metrics.

with no "fair trend."

All states should calculate these metrics, even those who believe that they will have high attendance rates. Standard attendance rates may dramatically underestimate student absenteeism, by neglecting students who would be in school but for the pandemic. These students should be included in the "equity check" in the hopes that they'll return to school rolls soon.

5. Defer high-stakes accountability until (at least) 2021-22.

6. Accept the USDOE invitation to waive the mandatory 95% participation adjustment.

7. Use three metrics to monitor learning and allocate support.

8. Allocate funding where equity indicators suggest there is greatest need.

Students and parents who want to test should be able to test, to know where they stand and help to allocate additional support. Students and parents for whom testing would be stressful or unsafe should be able to opt out. But the greater the number of students who are tested, the better we will be able to allocate support where it is most needed.

To build trust among teachers, parents and students, states should take the Department of Education's invitation for an accountability waiver. States should additionally commit that 2020-21 data will not be repurposed inappropriately for accountability metrics in the future.

This is a year when we should hold educators harmless and focus on student need. States should opt-out of accountability and opt-in to smart metrics for state testing.

The Challenges of Going Back to School

Posted on August 11, 2020 by WatchBlog

States and local governments are grappling with how to bring K-12 students back to school safely amidst the COVID-19 pandemic—whether in person, virtually, or via a hybrid model. Yet, even before COVID-19, several schools across the country had to close temporarily due to hazardous conditions in their facilities that posed health and safety risks to students, teachers, and staff.

Today's WatchBlog highlights the issues school districts need to address to make school buildings safe and to support learning as the 2020-2021 school year kicks off.

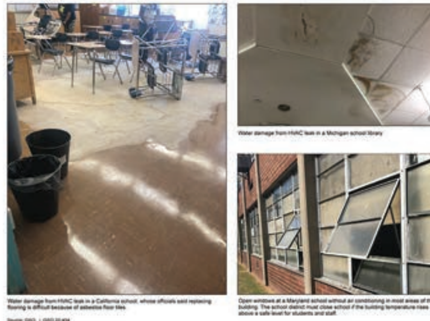
Poor building conditions

A leaky roof or a heating and cooling system needing repair can cause indoor air quality problems and exposure to mold or asbestos.

In 2019, we surveyed public school districts and found that an estimated 36,000 schools nationwide needed HVAC updates—a key component to ensuring proper ventilation in a school building.

In addition, the potential for lead to leach into water increases the longer the water remains in contact with faucets, pipes, or other plumbing that contains lead materials. Similar concerns exist for legionella—the bacteria that causes Legionnaires' disease. These are particular concerns for schools that are out of use for extended periods during which water in the plumbing system remains stagnant. The Centers for Disease Control recommends flushing water systems after prolonged building shutdown but we found that nearly 70% of school districts do not have flushing programs in place.

Examples of Issues with Heating, Ventilation, and Air Conditioning (HVAC) Systems in Public Schools



Water damage from HVAC leak in a Michigan school library

Water damage from HVAC leak in a California school, whose officials said replacing flooring is difficult because of asbestos floor tiles.

Open windows at a Maryland school without air conditioning in most areas of the building. The school district must close school if the building temperature rises above a safe level for students and staff.

Source: GAO. | GAO-20-494

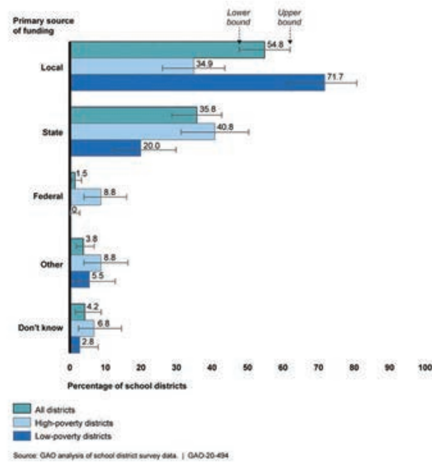
To learn more about our findings on the conditions of school facilities, tune into our podcast with GAO's K-12 education expert Jackie Nowicki.

00:00 00:00

High-poverty districts may struggle to fund repairs

The poorest school districts may be least able to afford necessary updates and repairs to their schools. We found significant differences between high-poverty and low-poverty districts in both the funding sources used and the total funds available for school facilities.

Estimated Percentage of School Districts by Primary Source of Funding for Public School Facilities



Based on our analysis of federal data on school district construction expenditures:

- Capital construction expenditures, on average, were about $300 less per student in high-poverty districts compared to low-poverty districts.
- About 1.5 million more students attended school in high-poverty districts than low-poverty districts, yet high-poverty districts spent about $1 billion less on capital construction.

Limited internet access

For school districts opting for virtual instruction this fall, reliable internet access at home will be crucial. In 2019, we found that school-age children in lower-income households may be more likely to rely on mobile wireless service for internet access. For their higher-income counterparts, in-home, fixed, high-speed internet access was more common. Mobile wireless can be less reliable and slower than in-home fixed service, which can make doing homework challenging. These difficulties will also disproportionately affect Black and Brown students, as roughly 80 percent of students attending low-income schools were either Black or Hispanic.

Students from lower-income households sometimes used public places like libraries and community centers to do their homework online—an option that may not be available due to COVID-19 closures and precautions.

The Federal Communications Commission's (FCC) E-rate program provides discounts on telecommunications and internet access services to schools. Schools with higher percentages of lower-income students get greater discounts, but E-rate support does not extend beyond the school premises. We recommended that the FCC assess and publish the potential benefits, costs, and challenges of making off-premises wireless access eligible for federal E-rate support.

In response to the COVID-19 pandemic, the FCC announced a new initiative—the Keeping Americans Connected Initiative—that, among things, aims to use $16 billion in CARES Act funding to promote remote learning with the Department of Education.

- Questions on the content of this post? Contact Jacqueline M. Nowicki and Andrew Von Ah at nowickij@gao.gov and vonaha@gao.gov.
- Comments on GAO's WatchBlog? Contact blog@gao.gov.

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April 2, 2020
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September 21, 2020
In "About GAO"

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Racial Disparities in Education and the Role of Government

Posted on June 29, 2020 by WatchBlog

The death of George Floyd and other Black men and women has prompted demonstrations across the country and brought more attention to the issues of racial inequality. Over the past several years, GAO has been asked to examine various racial inequalities in public programs and we have made recommendations to address them.

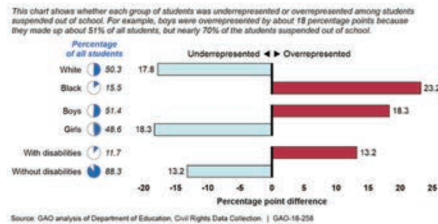
Today is the first of 3 blog posts in which we will address these reports. The first deals with equality in education.

School Discipline

Unequal treatment can start at a young age. In 2018, we reported that starting in pre-school, children as young as 3 and 4 have been suspended and expelled from school—a pattern that can continue throughout a child's education. In K-12 public schools, Black students, boys, and students with disabilities were disproportionately disciplined (e.g., suspended or expelled), according to our review of the Department of Education's national civil rights data.

These disparities were widespread and persisted regardless of the type of disciplinary action, level of school poverty, or type of public school attended. For example, while only 15.5% of public school students were Black, about 39% of students suspended from school were Black—an overrepresentation of about 23 percentage points (see figure).

Students Suspended from School Compared to Student Population, by Race, Sex, and Disability Status, School Year 2013-14



Note: Disparities in student discipline such as those presented in this figure may support a finding of discrimination, but taken alone, do not establish whether unlawful discrimination has occurred.

Minority students may also be more likely to attend alternative public schools because of issues like poor grades and disruptive behavior. In 2019, we found that Black boys transferred to alternative schools at rates higher than any other group for disciplinary reasons, and that they, along with Hispanic boys and boys with disabilities, attended alternative schools in greater proportions than they did regular public schools attended by the majority

of U.S. public school students. For example, Black boys accounted for 16 percent of students at alternative schools, but only 8 percent of students at regular public schools in 2015-16.

Education Quality and Access

The link between racial and ethnic minorities and poverty is long-standing. Studies have noted concerns about this segment of the population that falls at the intersection of poverty and minority status in schools and how this affects their access to quality education. In 2018, we reported that during high school, students in high-poverty areas had less access to college-prep courses. Schools in high-poverty areas were also less likely to offer math and science courses than most public 4-year colleges expected students to take in high school. The racial composition of the highest poverty schools was also 80% Black or Hispanic.

The Department of Education has several initiatives to help students prepare for college. For example, GEAR UP (Gaining Early Awareness and Readiness for Undergraduate Programs) seeks to increase the number of low-income students who are prepared to enter and succeed in postsecondary education. In 2016, Education awarded about $323 million in grants through GEAR UP.

In our 2018 report, we described an investigation the Department of Education conducted in 2014 looking at whether Black students in a Virginia school district had the same access to educational opportunities as other students. It found a significant disparity between the numbers of Black and White high school students who take AP, advanced courses, and dual-credit programs.

Addressing Disparity in Schools

So, what can be done to identify and address racial disparities in K-12 public schools? In 2016, we recommended that the Department of Education, which is to ensure equal access to education and promote educational excellence through vigorous enforcement of civil rights in our nation's schools, routinely analyze its Civil Rights dataset, which could help it identify issues and patterns of disparities. Our recommendation was implemented in 2018.

The Department of Justice also plays a role in enforcing federal civil rights laws in the context of K-12 education. For example, it monitors and enforces open federal school desegregation orders where Justice is a party to the litigation. At the time of our study, many of these desegregation orders had been in place for 30 and 40 years. For example, in a 2014 opinion in a long-standing desegregation case, the court described a long period of dormancy in the case and stated that lack of activity had taken its toll, noting, that the district had not submitted the annual reports required under the consent order to the court for the past 20 years. In 2016, we recommended that the Department of Justice systematically track key summary information across its portfolio of open desegregation cases to help inform its monitoring. Our recommendation was implemented in 2019.

To learn more about GAO's work on education, visit our key issues pages on Ensuring Access to Safe, Quality K-12 Education and Postsecondary Education Access and Affordability.

- Questions on the content of this post? Contact Jackie Nowicki at nowickij@gao.gov.
- Comments on GAO's WatchBlog? Contact blog@gao.gov.

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In "Education"

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August 28, 2018
In "Education"

Disciplining Public School Students
April 10, 2018
In "Education"

This entry was posted in Education, Racial Disparities and tagged Department of Education, Department of Justice, education, Education Workforce and Income Security, EWIS, Jackie Nowicki. Bookmark the permalink.

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National Council on Disability

An independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families.

Statement for the Record
U.S. House of Representatives
Committee on Education & Labor, Subcommittee on Early Childhood, Elementary, and Secondary Education
"Lessons Learned: Charting the Path to Educational Equity Post-COVID-19"
March 25, 2021

Chair Member Scott, Ranking Member Foxx, Subcommittee Chair Member Sablan, Ranking Subcommittee Member Owens, and Members of the Subcommittee, thank you for the opportunity to submit this Statement for the Record. On behalf of the National Council on Disability (NCD), we thank the subcommittee for the inclusion of additional funding in the American Rescue Plan of 2021, which President Biden signed into law on March 11, 2021. That funding is critically needed to support students with disabilities under the Individuals with Disabilities Education Act (IDEA) for the duration of the COVID-19 public health emergency. As a federal voice for the over 61 million Americans with disabilities, including students with disabilities and their families, NCD, an independent federal agency, provides advice to the President, his Administration, Congress, and federal agencies based on our comprehensive and objective analyses to inform policy development, improvement, and enforcement efforts. We are committed to advancing policy solutions that create a more inclusive society for people with disabilities.

Throughout the COVID-19 pandemic, disability advocates have been outspoken about concerns over the educational needs of students with disabilities during widespread school closures. The full extent of the effects of school closures and remote learning is not fully understood and requires deeper investigation. For this reason, since last year, NCD has been conducting a comprehensive study to examine the effects of the pandemic on people with disabilities across a range of policy topics that will include examination of students' experiences. We will present our findings before this subcommittee at the conclusion of our research in late summer.

The full integration of children with disabilities into society cannot be accomplished without access to a free and appropriate public education. Under ordinary circumstances, students with disabilities – about 14 percent of students from kindergarten to 12th grade, and more than 7 million children – already experienced enormous barriers in their education. Prior to the public health emergency, IDEA funding was sorely inadequate, causing delays and denials of services, and triggering unfair social resentment and discrimination.[1]

While the COVID-19 pandemic caused significant disruptions to the educational experiences of all students, it was especially disruptive for students with disabilities.

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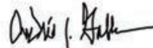
School districts' sudden reliance on distance learning as the sole option for education exacerbated the exclusion and isolation of students with disabilities. While some students are thriving in a remote classroom,[2] and some have fewer challenging behaviors at home, many more are losing out on educational opportunities during the protracted periods of lockdown and school closures.

The often overlapping problems experienced by students with disabilities include: barriers to accessing remote education related to equipment, technology and broadband; the inability of some students with disabilities to focus and learn during remote learning; the failure of schools to accommodate the needs of students with disabilities on remote platforms; the inability to receive services and supports that were provided in person or on school campuses, such as occupational therapy, speech and language therapy, behavioral and mental health supports, small group instruction, and one-on-one aides; among others. Those and other issues will be addressed in NCD's report this summer.

Given the detrimental effects that students with disabilities have experienced as a result of the extended school closures, future federal responses to the COVID-19 pandemic must include additional IDEA funding, as well as provide compensatory education services to allow students with disabilities to regain the skills that were disrupted, delayed or completely lost. In planning for future national emergencies, it is of critical importance that we invest in technology, equipment and connectivity, not only for students with disabilities to have an equal opportunity to engage and succeed in remote learning, if that is the only option, but also to ensure they continue to receive the services and supports that are essential for their academic success.

Most Respectfully,



Andrés J. Gallegos
Chairman

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[1] *See* National Council on Disability, *Broken Promises: The Underfunding of IDEA* 1, 13 (Washington, D.C.: Feb. 7, 2018) (describing how the federal government funds only 18 percent of IDEA costs, and how funding issues can cause delays in evaluations or rejection of requests for independent educational evaluations, inappropriate changes in placement and/or services, and failures to properly implement individualized education programs (IEPs), together with resentment and discrimination against children with

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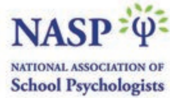
disabilities in their public schools),
https://ncd.gov/sites/default/files/NCD_BrokenPromises_508.pdf.
[2] *See* GAO, *Distance Learning*, *supra* n. _, at 18 (discussing students with social anxiety or other mental health conditions).



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The Honorable Gregorio Kilili Sablan
Chairman
U.S. House Subcommittee on Early Childhood,
Elementary and Secondary Education
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Burgess Owens
Ranking Member
U.S. House Subcommittee on Early Childhood,
Elementary and Secondary Education
2176 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman and Ranking Member,

Thank you for holding this critical hearing to discuss the importance of prioritizing equity in school reopening and beyond the immediate crisis of COVID-19. The National Association of School Psychologists (NASP) represents 24,000 school psychologists who work with students, families, educators, administrators, and others to meet the academic, social emotional, and mental and behavioral health needs of students. NASP believes that all children and youth must be ready to learn in order to achieve their best in school and graduate prepared for college or career. This requires establishing a public education infrastructure that empowers teachers to teach and prioritizes the academic, social–emotional, behavioral, and mental health needs of students. Additionally, we must make systemic efforts to ensure equitable access and opportunities for all students to thrive. Such efforts necessitate sustained access to comprehensive and robust curricula, high-quality instruction, social–emotional learning, academic and behavioral supports, and mental health services within safe, respectful, supportive, and inclusive learning environments. The challenges of the last 13 months as a result of COVID-19 and subsequent disruptions in learning and lost instructional time have presented an opportunity to address and remediate systemic barriers to equity in education.

COVID-19 has caused many students and educators to struggle; however, school closures and virtual learning have had a heightened impacted on students of color and students with disabilities. Assessment data from the fall of 2020 showed that students had learned only a fraction of what their peers would have typically learned at the same time, with those in schools that predominantly serve students of color suffering the most severe effects[1]. Following school closures in the spring of 2020, many students with disabilities that receive Individualized Education Programs (IEP) under the Individuals with Disabilities Education Act (IDEA) were unable to receive their required services in a virtual format and had to rely on untrained parents and caregivers to attempt to fulfill their child's IEP[2].

These inequities are also exacerbated by disparate access to technology and reliable high-speed internet. This problem, often referred to as the homework gap, prevents many students from fully succeeding in school and accessing the comprehensive resources they deserve. Recent data revealed that almost 17 million children lack the high-speed home internet access necessary to support online learning, including one in three Black, Hispanic, and American Indian/Alaska Native families. Two in five families in rural areas do not have access to high-speed home internet. Further, students experiencing homelessness are particularly difficult for schools to reach during closures and assess their well-being. These students often lack adequate shelter and sufficient food, let alone the high-speed internet access necessary to learn successfully outside of the classroom[3]. As classrooms become more dependent on virtual learning practices, Congress must work to ensure that all students have access to an even playing field, which includes accessible, affordable high-speed internet.

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[1] https://www.curriculumassociates.com/about/press-releases/2020/10/covid-learning-loss
[2] https://www.washingtonpost.com/local/education/special-education-students-are-not-just-falling-behind--theyre-losing-key-skills-parents-say/2020/08/05/ec1b91ca-cffd-11ea-9038-af089b63ac21_story.html
[3] https://www.edsurge.com/news/2021-01-11-schools-are-a-lifeline-for-homeless-students-covid-19-is-severing-the-connection

Congress must also prioritize equity when addressing the mental health needs of students as they continue to grapple with COVID-19 and its physical effects, economic instability and uncertainty, social justice and racial equity issues, isolation, and regular disruptions to daily life. Because the pandemic is forcing many schools to operate remotely or on hybrid schedules more than a year after closures began, there are concerns that children may be experiencing an increased need for mental health services without access to traditional supports available in the school setting. Although we continue to learn more about the impact of the pandemic on student mental health, recent research does indicate increases in self-reported anxiety, depression, when comparing May and June 2020 to pre-pandemic levels[4]. Even as more schools reopen for in-person learning, Black and Hispanic students are more likely to remain remote and continue to experience reduced access to school-based mental health supports. Further, while most students have struggled with changes to their routine and social isolation due to school closures, student with disabilities are expected to experience the greatest psychological impacts from these disruptions[5].

Unfortunately, resource gaps in K-12 public schools are also reflected in disparate access to school psychologists and other school-employed mental and behavioral health professionals. There is a critical shortage in school psychology, both in the number of practitioners and in the availability of graduate education programs and faculty. NASP recommends a ratio of one school psychologist per 500 students in order to provide comprehensive school psychological services. Current data estimate a national ratio of 1:1392; however, great variability exists among states, with some state approaching a ratio of 1:5000. Shortages are particularly severe in under-resourced and hard to serve communities. Shortages in school psychology, like shortages in other related education and mental health professions, have the potential to significantly undermine the availability of high-quality services to students, families, and schools. As schools look to prioritize the social emotional learning and mental and behavioral health needs of students and staff, we must act immediately to remedy the shortages of school psychologists by implementing solutions that attract people to the profession, provide them with proper graduate training, and ensure districts have the capacity and resources to recruit and retain these professionals.

Inequity in education existed long before COVID, but we have a unique opportunity to use significant federal investments to create an equitable public education system that serves all students. We cannot change actions or decisions made over the last year. However, we can look forward and begin to make meaningful changes to policy and practice that result in improved outcomes for all students. NASP recently published Ready to Learn, Empowered to Teach[6], which outlines six key guiding principles for public education:

1. Review, evaluate, and reconstruct or replace existing school structures, policies, and procedures that lead to inequitable outcomes.
2. Combine high expectations for all students with high-quality instruction across a well-rounded and culturally responsive curriculum for general and special education students.
3. Create positive school climates that balance physical and psychological safety for all students.
4. Provide access to comprehensive school based mental and behavioral health services and ensure adequate staffing levels of appropriately trained school employed mental health professionals.
5. Increase family and community engagement to support student success.
6. Create systems that support the recruitment and retention of properly trained and prepared professionals that reflect the diversity of the school community.
7. Create accountability systems that use a broad set of measures to inform specific actions that improve school quality and provide an understanding of how specific outcomes were achieved.

We urge Congress, and the Department of Education, to prioritize investments, guidance, and resources that address these key principles and help schools address the needs of students and communities most impacted by COVID-19 while simultaneously helping every state and district reexamine how they serve their students and families.

[4] Breaux, R., Dvorsky, M. R., Marsh, N. P., Green, C. D., Cash, A. R., Shroff, D. M., ... & Becker, S. P. (2021). Prospective impact of COVID-19 on mental health functioning in adolescents with and without ADHD: protective role of emotion regulation abilities. Journal of Child Psychology and Psychiatry. Advance online publication. doi: 10.1111/jcpp.13382
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7330593/
[6] file:///C:/Users/rmurdoch.NASP/Downloads/Ready%20to%20Learn%202020%20web%20(6).pdf

The historic investments in K-12 education authorized by the American Rescue Plan Act (ARPA) are sure to help schools provide high-quality education to all students; however, it is imperative that Congress provide full funding to Title I of the Every Student Succeeds Act and to the Individuals with Disabilities Education Act to ensure the long-term success of our public schools. Long-standing resource and opportunity gaps between our nation's richest and poorest schools have directly contributed to disparate educational and career outcomes for students. SEAs and LEAs have significant opportunity to utilize ARPA funds to address the comprehensive needs of their students, and Congress must help them sustain these efforts through robust funding of existing federal funding streams via the regular appropriations process.

School psychologists play a key role in problem solving and addressing issues of equity in their schools and communities. Their expertise should be utilized to the greatest extent possible as school leaders assess students' learning recovery and the resources needed for high-need student populations. While all students are expected to need intensive academic, social and emotional, and mental and behavioral supports and interventions, it is critical that Congress target resources to our most vulnerable students. Education is a civil right, and the federal government can, and should, play a critical role in shaping the nation's educational landscape by helping identify, evaluate, and promote promising and innovative practices; providing resources, guidance, and technical assistance for struggling schools and districts; and ensuring that a high-quality public education for all students remains a national priority.

If you have any questions or would like to follow up, please contact NASP Director, Policy and Advocacy, Kelly Vaillancourt Strobach at kvaillancourt@naspweb.org.

Sincerely,

Kathleen Minke, PhD, NCSP
Executive Director
National Association of School Psychologists

2021
COPING WITH COVID-19:
HOW YOUNG PEOPLE USE DIGITAL MEDIA TO MANAGE THEIR MENTAL HEALTH
common sense
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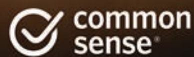

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Suggested citation: Rideout, V., Fox, S., Peebles, A., & Robb, M. B. (2021). *Coping with COVID-19: How young people use digital media to manage their mental health.* San Francisco, CA: Common Sense and Hopelab.

ISSN 2767-0163

2021

COPING WITH COVID-19:

HOW YOUNG PEOPLE USE DIGITAL MEDIA
TO MANAGE THEIR MENTAL HEALTH

COMMON SENSE IS GRATEFUL FOR THE GENEROUS SUPPORT
AND UNDERWRITING THAT FUNDED THIS RESEARCH REPORT:

Eva and Bill Price

Craig Newmark Philanthropies

Margaret and Will Hearst

Carnegie Corporation of New York

A LETTER FROM OUR FOUNDER

Founder and CEO James P. Steyer

March 2021 marks one year since the start of the coronavirus pandemic in the United States. One full year of lockdowns, remote school and work, and social distancing. One full year of illness, constant fear of what might be next, and anxiety about when things might go back to normal. Today there is certainly light at the end of the tunnel, as cases have begun to drop and vaccination efforts are rolling out around the world. Progress is slow, of course, but one year later we are in a better position to begin thinking about recovery. How do we return to an in-person world after a year of isolation and disruption? The first step is understanding the scale and scope of the toll the pandemic has taken on all of us, but especially young people.

To do that, we partnered with our friends at Hopelab and the California Health Care Foundation to review how young adults age 14 to 22 are leveraging social media and digital tools to support their mental health during the coronavirus pandemic. The report gives us a unique look inside the minds and actions of young people during the pandemic, as they navigated the loss of their social norms, their classrooms, and their connections with friends while also coping with the effects of a dangerous virus.

The findings of this report put the pandemic's impact on young adults into stark relief. First, the number of teens and young adults who report they are depressed has grown significantly since 2018. Nearly four in 10 (38%) teens and young adults report symptoms of moderate to severe depression, up substantially from 25% just two years ago. Among LGBTQ+ young people, depression rates remain at near-crisis levels, with 65% reporting these symptoms. Half (51%) of young people who had COVID-19 infections in their families also report symptoms of depression more often than those who have not. Contributing to this growth could be the increase in their exposure to hate speech on social media. One in four respondents reported they see hate speech "often" when they're online.

But there is a bright side: Social media and online tools have proven to be the lifeline that many young people needed to get through this last year. Teens and young adults are actively turning to online sources for information about their mental health during the pandemic. They're connecting with health professionals, finding communities for support, and researching tools and tips to help them cope. And overall, while social media continues to play a complex role in their lives, they report that using social media in this way makes them feel better, giving them hope and inspiration in a dark time.

Guiding our young people to the other side of this pandemic requires that we support them in their mental health journeys. From providing more digital tools to making online spaces as safe as possible, it's up to all of us to create a healthy digital ecosystem for young people. At Common Sense, we are committed to continuing to work with leaders in health, technology, business, and government to ensure all kids are ready for a post-pandemic world.

Jim Steyer

HOPELAB

Hopelab is delighted to have partnered with Common Sense and the California Health Care Foundation on this important report, ***Coping with COVID-19: How Young People Use Digital Media to Manage Their Mental Health***. The past 12 months have been nothing short of tumultuous. The pandemic, along with its corresponding stressors limiting vital human interactions, have had a significant impact on our collective mental health and well-being, and young people are no exception.

Young people are especially challenged because adolescence is a critically important time for developing identity and engaging in safe exploration as they transition from childhood to adulthood. During this time, younger adolescents are exploring and developing the skills they need to make good decisions and build their resilience. This is a period of intense learning about who they are and who they want to be, and they need space for positive interactions with peers to fully develop these skills.

Many of the findings in this report update the results of our own **national survey results**, *Digital Health Practices, Social Media Use, and Mental Well-Being Among Teens and Young Adults in the U.S.*, published in 2018. This allows us to examine the evolution of the meaning and role of technology in the lives and well-being of young people during this unprecedented period in history. Exploring the role that digital health tools and social media play in young people's mental well-being during a pandemic and contentious election has been extraordinary.

Understanding how young people respond to challenges, such as isolation, loneliness, depression, anxiety, and other mental health concerns, will allow us to adapt and create strategies to address the needs of young people more effectively. The data in this report also adds to the important conversation happening about how young people manage their mental health and well-being through online support systems.

At Hopelab, we believe wholly in the promise of adolescence and the power of young people as the innovators and creators of our collective future. The amplification of young people's voices and experiences found in this report gives funders, co-creators, developers, and partners a glimpse into the potential of Gen Z to leverage the powers of technology and improve well-being for their generation and generations to come.

If we are to fully support this vision, we have important work to do. This research suggests the need for even greater investment in the digital mental health space to support the development and equitable distribution of more evidence-based tools and therapies. At Hopelab, we are committed to supporting and improving the lives of young people through technology that supports positive behavior change. We invite our partners and the many organizations supporting young people to continue this journey with us, as we work to preserve the promise of adolescence and the well-being of future generations.

Sincerely,

Margaret Laws
President & CEO
Hopelab

The United States is experiencing three upheavals simultaneously. The first is a pandemic that has claimed far too many lives and continues to threaten the health of too many others. The second is a mental health crisis, as people deal with the personal, social, and economic consequences of that public health crisis. And the third is an awakening on matters of race—one that has featured an inspiring movement for justice as well as a backlash that was sometimes violent.

These events are taking a particular toll on the well-being of teens and young adults, who already faced substantial mental health challenges. Their schooling and social connections have been radically disrupted. Those seeking work face a volatile and highly diminished job environment. Many are afraid and anxious about the lives and livelihoods of their loved ones. At the same time, they cannot—and often do not—rely on traditional ways of getting help for their health or social needs.

Many of us have found ourselves relying even more heavily on digital media during these times. That has had major implications, both positive and negative, for teens and young adults. *Coping with COVID-19: How Young People Use Digital Media to Manage Their Mental Health* finds that nearly four in 10 teens and young people show symptoms of moderate or severe depression, up dramatically from just two years ago. It also presents alarming statistics and heartbreaking personal testimonials about young people's online experiences of racism and homophobia.

Yet the report also reveals how young people are using online health information, social media, apps, and other digital tools in innovative ways to connect with one another, stay informed, access services, and cope with depression and isolation. In their own voices, they share thoughtful and inspiring insights.

We all have a shared responsibility for creating the societal conditions that help young people thrive. I hope you find the rich insights in this report as meaningful, motivating, and compelling as I have.

Sandra R. Hernández, MD
President and Chief Executive Officer
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INTRODUCTION

THE PAST YEAR HAS been a tumultuous one in our country. The coronavirus pandemic killed hundreds of thousands of people and sickened millions more. It shut down schools and workplaces, cost millions of people their jobs, and put strict limits on in-person socializing. An especially bitter presidential election stoked acts of deadly violence, and police killings led to impassioned national protests for racial justice. Even before this challenging time, there was deep concern about the impact of the internet and social media on the health and well-being of young people in this country—both positive and negative. But in this unique situation in particular, those concerns are paramount. This report attempts to add data to an important conversation about how young people interact with mental health supports online.

This report documents the results of a nationally representative survey of more than 1,500 teens and young adults (age 14 to 22) in the United States. It was conducted during the coronavirus pandemic and presidential election season, from September to November 2020. Many of the findings update the results of a survey (Rideout & Fox, 2018) conducted two years earlier on behalf of Hopelab and Well Being Trust, allowing us to directly compare the results between the two cross-sectional samples and explore the evolution of the role of technology in young people's well-being during this extraordinary period.

The purpose of the report is to amplify young people's voices and experiences. We use a unique methodology that includes extensive use of open-ended questions, allowing teens and young adults to share their experiences in their own words. We received thousands of personal responses. We are then able to put those individual experiences within the context of the national quantitative data. The survey also includes a series of items that allow us to identify and take an even closer look at four distinct populations, for whom we have a special concern:

- First, those who are currently experiencing symptoms of depression, as indicated on the PHQ-8 depression scale (Kroenke et al., 2009).
- Second, those who have been most directly affected by COVID-19, in particular those who got sick themselves or had illness in their family.
- Third, young people who are at risk for problematic substance use, as assessed by the CRAFFT screener (Winters & Kaminer, 2008).
- And finally, LGBTQ+ youth, who our previous research (Rideout & Fox, 2018) indicated have extraordinarily high rates of depression and are especially active users of digital health resources.

Our survey is not a longitudinal study designed to understand any causal relationship between technology use and mental well-being. Instead, it is an effort to uncover how young people themselves experience social media, including:

- How it affects them when they are feeling depressed, stressed, or anxious.
- How they use social media to facilitate and support their own well-being.
- How they use other digital tools for health purposes, including using mobile apps, researching health topics online, taking advantage of telehealth services to connect to health providers, and seeking out peer health advice online.
- How they have used social media and digital health resources during the coronavirus pandemic in particular.

We hope that this data—and the personal experiences of teens and young adults as shared throughout the report—will shed light on how young people are navigating their own health challenges, the role that technology is playing, and how the adults and providers in their lives can best help meet their needs.

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Summary of methodology

- Nationally representative survey of 1,513 14- to 22-year-olds in the United States.
- Conducted by the National Opinion Research Center (NORC) at the University of Chicago.
- Data collected from September to November 2020.
- Offered online or by phone, in English or Spanish.
- Included extensive open-ended questions for respondents to share personal experiences.
- Findings were compared to separate cross-sectional surveys conducted in 2018.
- Data was analyzed by age, gender, race/ethnicity, and LGBTQ+ identity.
- Screeners were included in the survey to identify levels of depressive symptoms (PHQ-8) and risk for problematic substance use (CRAFFT).
- Changes over time and differences between subgroups were tested for statistical significance at the level of $p < .05$.
- For additional details, please see the Methodology section of this report.

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KEY FINDINGS

1. Nearly four in 10 (38%) teens and young adults report symptoms of moderate to severe depression, up substantially from 25% just two years ago.

The survey used the PHQ-8 scale (Kroenke et al., 2009) to assess symptoms of depression among respondents. Mirroring the findings of other studies (e.g., Czeisler et al., 2020), our survey finds that depression among 14- to 22-year-olds has increased significantly in a short period of time (see Table A). Symptoms of moderate to severe depression have nearly doubled among teens (from 13% to 25% among 14- to 17-year-olds) and have increased substantially among young adults (from 34% to 48% among 18- to 22-year-olds).

TABLE A. Depressive symptom levels, 2018 and 2020
Proportion of 14- to 22-year-olds with each level of symptoms

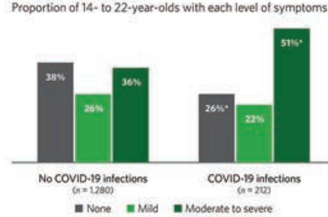
Level of depressive symptoms (PHQ-8 score, 0 to 24)	2018 (n = 1,334)	2020 (n = 1,492)
None (0 to 4)	**52%^{a}**	**37%^{b}**
Mild (5 to 9)	**23%**	**25%**
Moderate to severe (10 to 24)	**25%^{a}**	**38%^{b}**
• Moderate (10 to 14)	17%^{a}	23%^{b}
• Moderately severe (15 to 19)	5%^{a}	9%^{b}
• Severe (20 to 24)	3%^{a}	5%^{b}

Notes: Items with different superscripts differ significantly across rows ($p < .05$). A score of 10 or higher on the scale is considered a yellow flag warranting further attention.

2. Fully half (51%) of all young people who report a COVID-19 infection in their family also report symptoms of moderate to severe depression (compared to 36% of those who have not experienced COVID-19-related illness in their families).

The young people most directly affected by COVID-19—those who say that they themselves or someone in their family have gotten ill from the virus—are significantly more likely to manifest moderate to severe symptoms of depression than those who have not been affected in this way (see Figure A). One in seven (14%) young people in the survey said they or a family member had gotten sick from the virus. (The survey was conducted from September to November 2020; the rate is likely much higher now.) Black and Hispanic/Latinx teens and young adults were more than twice as likely as their White peers to say that they or

FIGURE A. Depressive symptom levels, by COVID-19 infections in family, 2020
Proportion of 14- to 22-year-olds with each level of symptoms



*Significantly different than among those without COVID-19 infections in the family, at the level of $p < .05$.

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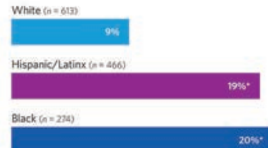
a family member had gotten sick with the virus (see Figure B). In addition to having the illness directly in their families, many young people have been affected in other ways, such as loss of income for themselves or their family (25%, as of fall 2020) or having to take on additional family responsibilities (18%), such as getting a job or taking on new child-care duties.

FIGURE B. COVID-19 infections in the family, by race/ethnicity, 2020
Percent of 14- to 22-year-olds who say they or a family member have gotten ill from the virus



*Significantly higher than among White youth, at the level of $p < .05$.

3. Exposure to hate speech on social media is up substantially over the past two years.

About one in four 14- to 22-year-olds say they "often" encounter body shaming (29%), racist (27%), sexist (26%), or homophobic (23%) comments on social media (see Figure C). Those in the targeted groups (e.g., Blacks for racist comments, or LGBTQ+ for homophobic ones) are more likely than others to be exposed to such comments. For example, three in 10 young women are "often" exposed to sexist comments, more than a third of young Black people are "often" exposed to racist comments, and more than four in 10 LGBTQ+ youth "often" encounter homophobic posts online.

Among 14- to 17-year-olds, the frequency of encountering such content on social media has increased significantly since 2018 (see Figure D; this item was not asked of 18- to 22-year-olds in 2018). For example, the percent of teens who say they "often" see racist content on social media has nearly doubled in the past two years (from 12% to 23%). We can't know from this survey whether these changes are due to a greater amount of negative content online, the increasing frequency of young people's social media use, an increase in young people's awareness of the negative content they are exposed to, or some other reason.

FIGURE C. Exposure to hate speech, 2020
Among 14- to 22-year-old social media users (n = 1,442), percent who say they encounter each type of content

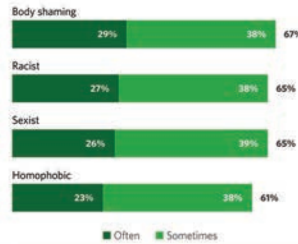


FIGURE D. Exposure to hate speech, 2018 and 2020
Among 14- to 17-year-old social media users, percent who say they "often" encounter each type of comment on social media

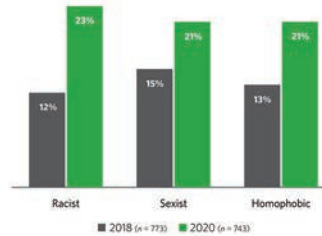


FIGURE D:
Note: 2018 trend data from the Common Sense Media survey *Social media, social life: Teens reveal their experiences*, conducted among 14- to 17-year-olds (Rideout & Robb, 2018). Differences between 2018 and 2020 in each category are statistically significant at the level of $p < .05$.

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4. Social media has played an important role in keeping young people informed and connected during the coronavirus pandemic, especially for those most directly affected by the virus.

About half (53%) of young people say social media has been "very" important to them during the pandemic for staying connected to friends and family, and about a third say it has been "very" important for keeping themselves informed about current events (34%) and learning how to protect themselves against the virus (31%) (see Table B). Those who say that they or a family member have been infected by the virus are more likely than their peers to consider social media "very" important in keeping up with current events (47% vs. 32%) and learning how to protect themselves from the virus (43% vs. 29%). When compared to their peers, it is clear that social media has played an especially important role in helping those who have been directly impacted by COVID-19.

"By connecting with other people, social media has helped me feel less isolated, and therefore less depressed."

—22-year-old woman

TABLE B. Importance of social media during the coronavirus pandemic, among all and by COVID-19 infections in the family, 2020

Among 14- to 22-year-old social media users, percent who say using social media during the coronavirus pandemic has been "very" important to them for ...	All (n = 1,442)	COVID-19 infection in the family	
		No (n = 1,231)	Yes (n = 211)
Being informed about current events	34%	32%[a]	47%[b]
Learning how to protect themselves against the virus	31%	29%[a]	43%[b]
Staying connected to family and friends	53%	53%	57%

Note: Items with different superscripts differ significantly across status of COVID-19 infection in family ($p < .05$).

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5. Young people make extensive use of a variety of digital health resources; those with depression are even more likely to do so.

More than eight in 10 (85%) young people have gone online to look for health information on a wide variety of topics, and nearly seven in 10 (69%) have used mobile apps related to health issues (see Table C). The health topics researched most frequently include COVID-19 (58%), fitness (47%), anxiety (42%), stress (39%), and depression (38%). The most commonly used health apps relate to fitness (39%), sleep (27%), menstruation (24%), nutrition (22%), and meditation (17%). Forty percent of young people have looked online for "health peers," or people with similar health concerns to their own.

Just less than half (47%) of 14- to 22-year-olds have connected with a health provider online, including more than one in four (27%) who have had a video appointment with a provider, and one in seven who have texted (15%) or used an online messaging system (14%) to connect with a health provider. The vast majority (86%) of those who have connected with a provider online say they found it helpful, including 37% who said "very" helpful (see Figure E). Of those who have not yet connected with a provider online, almost half (46%) are at least "somewhat" interested in doing so.

Digital health activity is even more common among young people with depression. Three out of four (75%) of those with moderate to severe depressive symptoms have used mobile apps related to health, nearly six in 10 (58%) have connected to health providers online, and half (51%) have looked online for people with health concerns similar to their own.

FIGURE E. Connecting to a health provider online: Attitudes and experiences, 2020

Among 14- to 22-year-olds who ...

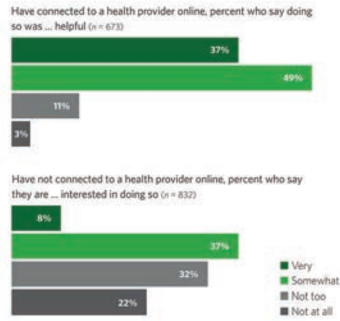

TABLE C. Online health resource use, by depressive symptom levels, 2020

Percent of 14- to 22-year-olds who say they have ...	Among all (N = 1,513)	Level of depressive symptoms: None (n = 643)	Mild (n = 339)	Moderate to severe (n = 510)
• Gone online for health information	85%	80%[a]	91%[b]	86%[b]
• Used mobile apps related to health	69%	61%[a]	73%[b]	75%[b]
• Connected with a health provider online	47%	37%[a]	46%[b]	58%[c]
• *Video appointment*	27%	23%[a]	24%[a]	33%[b]
• *Text messaging*	15%	9%[a]	15%[b]	20%[b]
• *Online messaging*	14%	7%[a]	10%[a]	21%[b]
• *An app*	12%	7%[a]	11%[ab]	18%[b]
• Looked for people with similar health concerns online	40%	28%[a]	39%[b]	51%[c]

Note: Items with different superscripts differ significantly by level of depressive symptoms ($p < .05$).

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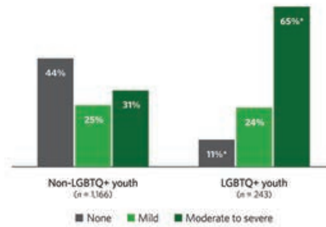
6. Nearly two out of three LGBTQ+ youth report moderate to severe symptoms of depression, twice the rate among non-LGBTQ+ young people.

Sixteen percent of the respondents in our survey identify as gay, lesbian, bisexual, transgender, nonbinary, or "other" sexual orientation or gender identity, and are therefore identified in this report as LGBTQ+. Among these young people, fully two out of three (65%) report moderate to severe symptoms of depression, twice the rate among non-LGBTQ+ youth (31%) (see Figure F). LGBTQ+ teens and young adults make extensive use of digital health resources for both physical and mental health purposes, including looking up health information online, using health-related mobile apps, connecting to health providers online, and trying to find people online with similar health concerns (see Table D).

FIGURE F. Depressive symptoms, by LGBTQ+ identity, 2020
Percent of 14- to 22-year-olds with each level of depressive symptoms



*Significantly different than non-LGBTQ+ youth at the level of $p < .05$.

TABLE D. Online health seeking, by LGBTQ+ identity, 2020

Among 14- to 22-year-olds, percent who say they have ever ...	Non-LGBTQ+ (n = 1,179)	LGBTQ+ (n = 248)
Looked for health information online	83%[a]	92%[b]
Used a mobile health app	68%	74%
Connected to health providers online	45%[a]	57%[b]
Tried to find people online with similar health concerns to their own	38%[a]	53%[b]

Note: Items with different superscripts differ significantly across rows ($p < .05$).

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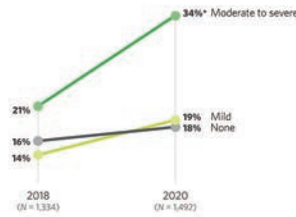
7. Young people with moderate to severe depressive symptoms are nearly twice as likely as those without depression to say they use social media almost constantly (34% vs. 18%).

It is not possible to say whether social media use is driving depression or whether people who are depressed are using social media more frequently (see Table E). But we do know that over the past two years, young people with moderate to severe depressive symptoms have begun using social media more frequently: In 2018, 21% said they used social media "almost constantly," and in 2020 34% did (see Figure G). Whether this is a permanent increase or an artifact of the pandemic, only future research will tell. Overall, one in four (25%) young people say they are on social media "almost constantly," up from 17% in 2018.

FIGURE G. Frequency of social media use, by depressive symptom levels, 2018 and 2020

Percent of 14- to 22-year-olds who say they use social media "almost constantly"



*Significantly higher than 2018, at the level of $p < .05$.

TABLE E. Frequency of social media use, by depressive symptom levels, 2020

Percent of 14- to 22-year-olds who say they use social media ...	Level of depressive symptoms		
	None (n = 643)	Mild (n = 339)	Moderate to severe (n = 510)
Almost constantly	18%[a]	19%[a]	34%[b]
Daily, but not constantly	64%[a]	64%[a]	44%[b]
Less than daily	13%	12%	18%
Never	5%	5%	4%

Note: Items with different superscripts differ significantly across rows ($p < .05$).

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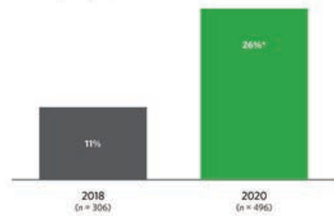
8. Social media platforms have become even more important to young people for support, community, and self-expression over the past two years, especially for those experiencing depression.

More than one in five teens and young adults say social media is "very" important to them for getting support or advice when needed (20%), feeling less alone (21%), getting inspiration from others (23%), and expressing themselves creatively (25%), all of which are substantial increases from 2018 (see Table F). Young people with depression are even more likely to consider social media "very" important than those without depression. For example, 28% of those with moderate to severe depressive symptoms say social media is "very" important for feeling less alone, compared to 13% of those without depression. The proportion of young people with depression who say social media is "very" important for getting support or advice when they need it has more than doubled in the past two years, up from 11% in 2018 to 26% today (see Figure H).

FIGURE H. Importance of social media, among those with depression, 2018 to 2020

Among 14- to 22-year-olds with moderate to severe depressive symptoms, percent who say social media is "very" important to them for getting support and advice



*Significantly higher than 2018, at the level of $p < .05$.

TABLE F. Importance of social media, by year of data collection and depressive status in 2020

Percent of 14- to 22-year-old social media users who say social media is "very" important to them for ...	Data collection		Level of depressive symptoms		
	2018 (n = 1,242)	2020 (n = 1,422)	None (n = 609)	Mild (n = 317)	Moderate to severe (n = 496)
Getting support/advice when needed	12%[a]	20%[b]	15%[a]	19%[ab]	26%[b]
Expressing themselves creatively	18%[a]	25%[b]	20%[a]	27%[ab]	27%[b]
Getting inspiration from others	18%[a]	23%[b]	17%[a]	20%[a]	29%[b]
Feeling less alone	15%[a]	21%[b]	13%[a]	20%[b]	28%[c]

Note: Items with different superscripts differ significantly across rows within each category ($p < .05$).

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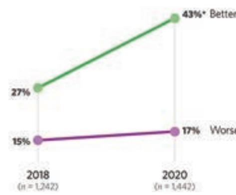
9. Young people are far more likely to say that using social media makes them feel better rather than worse when they're depressed, stressed, or anxious, and that rate has gone up substantially since 2018.

Forty-three percent of 14- to 22-year-old social media users say that when they feel depressed, stressed, or anxious, using social media usually makes them feel better, compared to just 17% who say it makes them feel worse (see Figure I). (The rest say it makes no difference either way.) In 2018, 27% said using social media at these times made them feel better, compared to the 43% who say so now. However, for those who have severe depression (PHQ-8 score of 20 to 24, 5% of our total sample), social media plays an outsized role—more important for inspiration, support, and connection, but also more likely to make respondents more anxious, lonely, and depressed. Because the sample size of respondents with severe depression is so small, findings among this group should be viewed with caution. But whether we're considering the positive or the negative effects of social media, its impact on those experiencing the highest levels of depression deserves special consideration.

FIGURE I. Effect of social media when feeling depressed, stressed, or anxious, among all, 2018 to 2020

Among 14- to 22-year-old social media users, percent who say using social media when they are depressed, stressed, or anxious usually makes them feel ...



*Significantly higher than 2018, at the level of $p < .05$.

10. About one in 10 (9%) young people in the survey is at risk for problematic substance use, and 46% of those respondents say they have sought information about drug and alcohol abuse online.

In this survey, the CRAFFT screener (Knight et al., 2002; Winters & Kaminer, 2008) was used to identify those at risk for problematic substance use. These young people were more likely than their peers to have engaged in a number of online health-seeking activities, including looking up information on drug and alcohol abuse, trying to find others online with similar health conditions, and using digital tools to connect to providers (see Table G).

TABLE G. Digital health use, by risk for problematic substance use, 2020

	Risk for problematic substance use	
Among 14- to 22-year-olds, percent who have ...	No (n = 1,358)	Yes (n = 143)
Looked up online information about drug and alcohol abuse	15%[a]	46%[b]
Tried to find others online with the same health issues	38%[a]	57%[b]
Connected with health providers online	46%[a]	60%[b]
Used a mobile app related to drug and alcohol abuse	2%[a]	13%[b]

Note: Items with different superscripts differ significantly across rows ($p < .05$).

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DIGITAL HEALTH PRACTICES AMONG TEENS AND YOUNG ADULTS

WHEN WE THINK ABOUT young people and digital media, it is easy to focus on the use of technology for entertainment and socialization, such as watching funny videos, playing games, following celebrities, and chatting with friends online. But in addition to these activities, the vast majority of teens and young adults are also using digital media for health-related purposes, including looking up information about various health issues online, using mobile apps to promote their well-being, connecting with health providers by text or video, and seeking advice from peers with health concerns similar to their own.

As indicated in Table 1 below, more than eight in 10 (85%) young people have gone online to look for health information, and nearly seven in 10 (69%) have used mobile apps related to health issues. Nearly half (47%) have connected with a provider online, and four in 10 (40%) have looked online for "health peers" (people with health concerns similar to their own).

There is some variation in the use of online health resources by age, gender, and race/ethnicity. Young adults (age 18 to 22) are more likely than teens (age 14 to 17) to use health-related mobile apps, connect to health providers over the internet, and look for people online with similar health concerns. Female teens and young adults are more likely than males to look for health information online and use mobile apps related to health, and White young people are more likely than their Black peers to look for health information online.

Searching for health information online. As mentioned previously, a total of 85% of young people have searched for health information online. Not surprisingly, given that the survey was conducted from September to November 2020, COVID-19 was the most common health topic researched online (58% of teens and young adults looked for information on COVID-19), followed by searches for information on fitness and exercise (47%). Anxiety (42%), stress (39%), and depression (38%) round out the top five health issues that young people searched online (see Table 2 on page 12).

"I looked at several depression and anxiety subreddits, found good advice and different ways to look at the problem."

—22-year-old man

While the total percentage of youth who search for health information online has held steady since 2018, there have been some interesting changes over the past two years in the types of topics young people are researching. Fewer young people are searching

TABLE 1. Online health resource use, by year of data collection, and by age, gender, and race/ethnicity in 2020

	Data collection		Age		Gender		Race/Ethnicity		
Among 14- to 22-year-olds, percent who say they have ever ...	2018 (N = 1,337)	2020 (N = 1,513)	14 to 17 (n = 796)	18 to 22 (n = 717)	Male (n = 695)	Female (n = 778)	White (n = 613)	Black (n = 274)	Hispanic/ Latinx (n = 466)
Searched for health information online	87%	85%	85%	84%	82%[a]	88%[b]	86%[a]	77%[b]	86%[ab]
Used mobile apps related to health	64%[a]	69%[b]	65%[a]	72%[b]	61%[a]	77%[b]	68%	70%	67%
Connected to health providers online	20%[a]	47%[b]	42%[a]	51%[b]	45%	50%	49%	44%	43%
Looked for people with similar health concerns online	39%	40%	36%[a]	43%[b]	37%	42%	39%	39%	39%

Note: Items with different superscripts differ significantly across rows within each category ($p < .05$).

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for information about fitness or nutrition (down 16 and 14 percentage points, respectively), and searches related to sexual activity have also dropped substantially, including birth control (down 10 percentage points), pregnancy (down 10 percentage points), and sexually transmitted diseases (down 7 percentage points).

There are several notable differences between demographic groups in terms of their health information searches. Young adults are more likely than teens to search for health information on a variety of topics, including anxiety, stress, depression, sleep disorders, STDs, and pregnancy. Female teens and young adults are more likely than their male peers to search for health information online (88% vs. 82%), with quite substantial differences when it comes to mental health issues such as anxiety (a difference of 21 percentage points), stress (15 percentage points), depression (17 percentage points), and eating disorders (18 percentage points). Not surprisingly, female teens and young adults are also more likely than males to search for information on pregnancy (a difference of 19 percentage points) and birth control (23 percentage points).

Black teens and young adults are less likely than either Hispanic/Latinx or White youth to look for health information online (overall, 77% of Black young people have done so, compared to 86% of those who are Hispanic/Latinx and White). There are a number of topical differences by race/ethnicity as well. For example, 49% of Black young people have looked online for information related to COVID-19, compared to 60% of White youth. The differences are most stark between Black and White young people on a variety of specific topics, including anxiety (a difference of 19 percentage points), stress (15 percentage points), and depression (16 percentage points), with Black young people less likely to research each topic online.

TABLE 2. Online health information searches, by year of data collection, and by age, gender, and race/ethnicity in 2020

Among 14- to 22-year-olds, percent who have ever searched online for information about ...	Data collection		Age		Gender		Race/Ethnicity		
	2018 ($N = 1,337$)	2020 ($N = 1,513$)	14 to 17 ($n = 796$)	18 to 22 ($n = 717$)	Male ($n = 695$)	Female ($n = 778$)	White ($n = 613$)	Black ($n = 274$)	Hispanic/Latinx ($n = 466$)
COVID-19	NA	58%	57%	58%	56%	60%	60%[a]	49%[b]	54%[ab]
Fitness and exercise	63%[a]	47%[b]	45%	48%	45%	49%	48%	41%	49%
Anxiety	42%	42%	35%[a]	47%[b]	31%[a]	52%[b]	46%[a]	27%[b]	39%[a]
Stress	44%[a]	39%[b]	35%[a]	42%[b]	31%[a]	46%[b]	42%[a]	27%[b]	37%[a]
Depression	39%	38%	33%[a]	42%[b]	29%[a]	46%[b]	41%[a]	25%[b]	36%[a]
Diet and nutrition	52%[a]	38%[b]	35%	40%	33%[a]	43%[b]	40%[a]	28%[b]	37%[a]
Sleep disorders	27%	25%	21%[a]	29%[b]	20%[a]	30%[b]	26%[a]	16%[b]	28%[a]
Smoking or vaping	20%	24%	22%	25%	23%	24%	23%	23%	25%
Birth control	30%[a]	20%[b]	15%	24%	8%[a]	31%[b]	21%	16%	20%
Sexually transmitted diseases	26%[a]	19%[b]	16%[a]	21%[b]	17%	20%	17%	23%	17%
Drug or alcohol abuse	24%[a]	19%[b]	18%	19%	16%	21%	20%	15%	18%
Pregnancy	28%[a]	18%[b]	13%[a]	23%[b]	9%[a]	28%[b]	17%	16%	21%
Eating disorders	19%[*]	18%	17%	19%	9%[a]	27%[b]	20%[a]	11%[b]	15%[ab]
Cancer	24%[a]	17%[b]	15%	18%	13%[a]	20%[b]	18%	15%	14%
Diabetes	17%[*a]	12%[b]	8%[a]	14%[b]	9%	13%	11%	10%	11%
Heart disease	14%[a]	7%[b]	5%[a]	9%[b]	8%	7%	6%	9%	6%
Any other mental health issue	6%	8%	5%[a]	9%[b]	6%	9%	7%	6%	7%
Any other physical health issue	6%	6%	5%	6%	5%	6%	8%[a]	2%[b]	4%[b]
Any health topic	**87%**	**85%**	**85%**	**84%**	**82%**[a]	**88%**[b]	**86%**[a]	**77%**[b]	**86%**[a]

[*]The 2018 report erroneously listed these findings 1% lower.

Note: Items with different superscripts differ significantly across rows within each category ($p < .05$).

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Use of health-related mobile apps. Nearly seven out of 10 (69%) young people have used mobile apps related to health, up slightly from 2018 (64%). Fitness tops the list of health-related apps used by young people (see Table 3), with about four in 10 (39%) saying they have used one. More than one in four (27%) young people have used apps related to sleep, and nearly one in five (17%) have used meditation or mindfulness apps. The use of apps related to fitness and nutrition has declined somewhat since two years ago, but apps related to sleep, meditation, stress reduction, and depression are up. Still, fewer than one in 10 (9%) young people say they have ever used an app specifically related to depression.

Young adults are more likely to use health-related apps than teens, and female teens and young adults are more likely to use them than their male peers. The biggest differences by age are in the use of apps related to sleep (a difference of 8 percentage points) and stress reduction (7 percentage points). Unsurprisingly, female teens and young adults are more likely to use apps related to menstruation (47% female vs. 2% male), but they are also more likely to use meditation or mindfulness apps (23% vs. 10%), and mood trackers (15% vs. 5%). There are no racial or ethnic differences in the overall proportion of young people who use health-related apps, but there are a handful of differences by topic area: Whites are more likely than others to use apps related to fitness, sleep, and meditation, and Black teens and young adults are more likely than White or Hispanic/Latinx young people to use apps related to depression (14%, compared to 8% of White and Hispanic/Latinx).

"I was having trouble sleeping since the virus outbreak, so I talked to a doctor and this gave me the courage to try meditation which soon allowed me to relax during those periods."

—15-year-old girl

TABLE 3. Health-related mobile app use, by year of data collection, and by age, gender, and race/ethnicity in 2020

Among 14- to 22-year-olds, percent who have ever used apps related to ...	Data collection		Age		Gender		Race/Ethnicity		
	2018 (N = 1,337)	2020 (N = 1,513)	14 to 17 (n = 796)	18 to 22 (n = 717)	Male (n = 695)	Female (n = 778)	White (n = 613)	Black (n = 274)	Hispanic/ Latinx (n = 466)
Fitness	45%^{a}	39%^{b}	41%	37%	36%	43%	41%^{a}	39%^{ab}	34%^{b}
Nutrition	26%^{a}	22%^{b}	21%	24%	22%	24%	23%	23%	19%
Sleep	20%^{a}	27%^{b}	22%^{a}	30%^{b}	25%	28%	30%^{a}	20%^{b}	22%^{b}
Period/menstruation	20%^{a}	24%^{b}	23%	24%	2%^{a}	47%^{b}	26%	21%	20%
Meditation/mindfulness	11%^{a}	17%^{b}	16%	19%	10%^{a}	23%^{b}	20%^{a}	13%^{ab}	12%^{b}
Stress reduction	9%^{a}	14%^{b}	10%^{a}	17%^{b}	10%^{a}	17%^{b}	14%	11%	13%
Medication reminder	7%	7%	6%	7%	3%^{a}	10%^{b}	7%	6%	8%
Birth control	7%	6%	4%^{a}	8%^{b}	1%^{a}	11%^{b}	6%	9%	6%
Mood tracker	6%^{a}	10%^{b}	8%^{a}	12%^{b}	5%^{a}	15%^{b}	11%	10%	7%
Depression	5%^{a}	9%^{b}	7%^{a}	11%^{b}	7%	11%	8%^{a}	14%^{b}	8%^{a}
Quitting smoking/vaping	4%^{a}	2%^{b}	3%	2%	2%	2%	2%	4%	3%
Drug or alcohol abuse	2%^{a}	3%^{b}	3%	3%	4%	3%	2%^{a}	5%^{b}	4%^{ab}
COVID-19 tracker	NA	11%	12%	11%	12%	11%	10%	13%	10%
Any other health issue	1%	1%	1%	1%	1%	1%	1%	0%	1%
Any health app	**64%^{a}**	**69%^{b}**	**65%^{a}**	**72%^{b}**	**61%^{a}**	**77%^{b}**	**68%**	**70%**	**67%**

Note: Items with different superscripts differ significantly across rows within each category ($p < .05$).

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Connecting with health providers online. Nearly half (47%) of all young people have used digital tools to connect with health providers, and the vast majority found it helpful. As indicated in Table 4, more than one in four (27%) have had a video appointment with a provider, and one in seven have texted (15%) or used online messaging (14%). All represent increases from two years ago. The largest increase in telehealth has been in video appointments, but it is possible that some of this change is the result of a difference in question wording from 2018 to 2020: In 2018, the survey asked whether respondents had connected to providers via "video chat," whereas in 2020 it asked about "video appointments." In addition, of course, the closure of many medical facilities during shelter-in-place orders also likely affected the use of video appointments.

The vast majority (86%) of those who have connected with a provider online say they found it helpful, including 37% who said "very" helpful (see Table 5 on page 15). Only 14% said the experience was not helpful. Of those who have not yet connected with a provider online, 45% are either "very" (8%) or "somewhat" (37%) interested in doing so. The main reasons most young people offer for not wanting to connect with providers online are that they either don't have any health issues that need attention (48%) or that they simply prefer to meet their providers face to face (52%). Only small proportions report being worried about confidentiality or privacy.

There are only a few differences by age, gender, or race/ethnicity when it comes to 14- to 22-year-olds' interest in taking advantage of telehealth opportunities. Young adults are more likely than teens to have connected with a health provider online (51% vs. 42%), and they are more likely to be concerned about cost and security issues. Female young people are more interested than males in connecting with a provider online (51% vs. 40%), and White youth are more concerned than Hispanics/Latinx about the security and confidentiality of their health information online (14% vs. 5%).

Looking for health peers online. Four in 10 (40%) young people say they have gone online to seek out people who have similar health concerns as their own, nearly the same rate as two years ago (see Table 1 on page 11). This could be through watching video testimonials, reading blogs, listening to podcasts, or joining social media groups. Young adults are more likely than teens to have done this (43% vs. 36%); male and female young people, and White, Black, and Hispanic/Latinx young people are all equally likely to have tried to connect with health peers online. (See quotes on page 16.)

TABLE 4. Connecting to health providers online, among all, 2018 and 2020

Percent of 14- to 22-year-olds who have connected to online health providers via ...	2018 (N = 1,337)	2020 (N = 1,513)
Video appointment*	4%[a]	27%[b]
Text messaging	8%[a]	15%[b]
Online messaging	10%[a]	14%[b]
An app	5%[a]	12%[b]
Other	NA	4%
Any of the above	**20%[a]**	**47%[b]**

*In 2020, question wording changed from "video chat" to "video appointment." Therefore differences over time may not be comparable.

Note: Items with different superscripts differ significantly across rows ($p < .05$).

"I prefer in-person sessions, but due to COVID, it has been helpful to safely talk with my therapist on the phone. I always have the option to do video conferencing, but I don't have internet in a place I can privately communicate with my therapist."

—21-year-old woman

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TABLE 5. Connecting to a health provider online: Attitudes and experiences, by age, gender, and race/ethnicity, 2020

		Age		Gender		Race/Ethnicity		
Among 14- to 22-year-olds, percent who have ...	**All** (N = 1,513)	**14 to 17** (n = 796)	**18 to 22** (n = 717)	**Male** (n = 695)	**Female** (n = 778)	**White** (n = 613)	**Black** (n = 274)	**Hispanic/ Latinx** (n = 466)
Connected to a health provider online	**47%** (n = 673)	**42%[a]** (n = 317)	**51%[b]** (n = 356)	**44%** (n = 288)	**50%** (n = 363)	**49%** (n = 270)	**44%** (n = 121)	**43%** (n = 207)
Among those who have connected to a health provider online, percent who say doing so is generally ...								
• Very/somewhat helpful	86%	90%	83%	88%	86%	84%	88%	89%
• *Very helpful*	*37%*	*45%[a]*	*31%[b]*	*41%*	*35%*	*35%*	*42%*	*36%*
• *Somewhat helpful*	*49%*	*45%*	*52%*	*48%*	*51%*	*49%*	*46%*	*53%*
• Not too/at all helpful	14%	10%	17%	12%	15%	16%	12%	11%
• *Not too helpful*	*11%*	*7%*	*13%*	*10%*	*11%*	*11%*	*9%*	*9%*
• *Not at all helpful*	*3%*	*3%*	*3%*	*2%*	*3%*	*4%*	*3%*	*2%*
Have not connected to a health provider online	**52%** (n = 832)	**57%[a]** (n = 474)	**48%[b]** (n = 358)	**55%** (n = 404)	**49%** (n = 410)	**51%** (n = 341)	**54%** (n = 151)	**57%** (n = 258)
Among those who have not connected to a health provider online, percent who say they are ... in doing so								
• Very/somewhat interested	46%	43%	48%	40%[a]	51%[b]	43%	50%	50%
• *Very interested*	*8%*	*9%*	*8%*	*8%*	*9%*	*7%*	*14%*	*10%*
• *Somewhat interested*	*37%*	*34%*	*40%*	*32%[a]*	*43%[b]*	*35%*	*36%*	*40%*
• Not too/at all interested	54%	56%	52%	59%[a]	48%[b]	57%	50%	49%
• *Not too interested*	*32%*	*33%*	*32%*	*37%[a]*	*27%[b]*	*35%*	*26%*	*28%*
• *Not at all interested*	*22%*	*23%*	*20%*	*22%*	*21%*	*22%*	*24%*	*21%*
Among those who are not interested in connecting with a health provider online, percent who ...	(n = 439)	(n = 258)	(n = 181)	(n = 237)	(n = 194)	(n = 201)	(n = 68)	(n = 123)
Would rather meet or talk to health providers in person	52%	48%	56%	53%	50%	55%	+	45%
Don't have any health issues to see a provider about	48%	56%[a]	39%[b]	50%	46%	52%	+	47%
Worry about the security or confidentiality of their health information online	10%	4%[a]	17%[b]	8%	14%	14%[a]	+	5%[b]
Worry about the cost	10%	5%[a]	16%[b]	10%	11%	11%	+	7%
Worry about being overheard	5%	4%	5%	5%	5%	5%	+	4%
Worry about family finding out	5%	4%	6%	1%[a]	9%[b]	6%	+	2%
Other	6%	6%	5%	4%	7%	4%	+	7%

+Cell size too small for reliability.

Note: Items with different superscripts differ significantly across rows within each demographic category ($p < .05$).

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We asked respondents to share their experience about a time they connected online with a clinician, including whether it was helpful. Young people shared what worked well and what could be improved.

Some examples:

"It was helpful because I felt as though I was talking to her in person."

—14-year-old boy

"It was a great experience with the stress of COVID. It was safe to communicate with my provider without actually going to the hospital. It was also fast. Everything was great with this connection."

—15-year-old boy

"It was an OK experience, but it was not the same as speaking with them in person. I didn't feel comfortable expressing myself online."

—16-year-old girl

"I got ideas ... stress coping and anxiety reducing strategies I can use on an everyday basis."

—17-year-old boy

"She was distracted and unhelpful."

—21-year-old woman

"Me meeting with my doctor online was about my depression, we had to do it online because COVID struck and everything was locked down. It was kind of nice not having to leave the house to talk to a doctor, but it was less personal than if you actually went to the doctor's. You could train the doctors to look at the camera more to seem like they are looking at you."

—20-year-old man

"I like seeing someone in person and humanizing them a bit before I open up to them. To have a counselor online was not my cup of tea."

—21-year-old woman

We asked respondents who had gone online to try to find health peers to share more about the situation and how it turned out.

Here are some of their stories:

"Once I was searching on the internet to find [out] what other people have and found someone who surprised me as he has almost the same health concerns as me."

—14-year-old boy

"Sometimes I get depressed or anxious about certain things that I deal with, and I wanted to know if other teens felt the same way I do. I found others who sometimes feel like I do, and what they do to overcome it."

—16-year-old girl

"Wanted to find other people my age that are overweight."

—16-year-old girl

"I found friends in my city who were experiencing the same things. I felt understood after messaging them."

—17-year-old boy

"I just went out looking for people that are in the same position I am, and we were able to connect and understand that we weren't alone like we thought we were."

—19-year-old man

"I looked through those forums and found people with my same issue. It helped me find out how to control it."

—19-year-old woman

"It was great. I wanted to see if I could relate to others and turns out I did—ended up having an online friend whom I call almost every day."

—20-year-old man

"I went on Facebook and found a few people that had the same issues as I did. I was pregnant and needed help, and they ended up being super super nice."

—22-year-old woman

"I am in a Facebook group for lactose intolerance and one for anxiety. It's nice to have a space to vent with people who understand and to share resources."

—22-year-old woman

"I used to find others on social media who struggled with the same issues I did by joining group pages. It was nice to not feel alone, and I made a few friends even."

—22-year-old woman

DEPRESSION AND COVID-19 AMONG TEENS AND YOUNG ADULTS

THIS SURVEY INCLUDED A widely used scale for measuring depressive symptoms, the PHQ-8 scale (Kroenke et al., 2009). We were also interested in documenting the varying degrees to which young people's lives have been affected by COVID-19, and exploring any links between COVID-19 and depression. Therefore we also included in our survey a series of questions about various types of impacts young people may have experienced due to COVID-19. This section of the report provides an overview of the results concerning levels of depression, COVID-19-related impacts, and the relationship between the two.

Depression. Disturbingly, the survey finds that nearly four out of 10 (38%) young people between 14 and 22 years old report symptoms of moderate to severe depression (see Table 6). Mirroring the findings of other studies (e.g., Czeisler et al., 2020), our survey finds a substantial increase in depression among this age group, from 25% in 2018 to 38% in 2020. Depression levels are substantially higher among 18- to 22-year-olds (48% report moderate to severe symptoms) than among 14- to 17-year-olds (25%). But the increase among the younger group has been substantial, with the proportion reporting moderate to severe symptoms nearly doubling from 13% in 2018 to 25% today (see Table 7). Among young adults, the rate went from 34% to 48% over that same time period. With respect to gender, the percent of females reporting symptoms of moderate to severe depression significantly increased from 30% in 2018 to 39% in 2020; among males, it significantly increased from 18% to 35%.

TABLE 6. Depressive symptom levels, by year of data collection, and by age, gender, and race/ethnicity in 2020

Among 14- to 22-year-olds, percent who score in each level of depressive symptoms (PHQ-8, score of 0 to 24):	Data collection		Age		Gender		Race/Ethnicity		
	2018 (N = 1,334)	2020 (N = 1,492)	14 to 17 (n = 789)	18 to 22 (n = 703)	Male (n = 687)	Female (n = 766)	White (n = 606)	Black (n = 269)	Hispanic/ Latinx (n = 458)
None (0 to 4)	**52%[a]**	**37%[b]**	**50%[a]**	**27%[b]**	**42%[a]**	**34%[b]**	**34%[a]**	**46%[b]**	**40%**
Mild (5 to 9)	**23%**	**25%**	**26%**	**25%**	**23%**	**27%**	**30%[a]**	**16%[b]**	**24%**
Moderate to severe (10 to 24)	**25%[a]**	**38%[b]**	**25%[a]**	**48%[b]**	**35%**	**39%**	**36%**	**37%**	**37%**
• Moderate (10 to 14)	17%[a]	23%[b]	14%[a]	31%[b]	22%	25%	22%	24%	25%
• Moderately severe (15 to 19)	5%[a]	9%[b]	6%[a]	12%[b]	8%	9%	9%	8%	9%
• Severe (20 to 24)	3%[a]	5%[b]	5%	6%	5%	5%	5%	5%	4%

TABLE 7. Depressive symptom levels, by age, 2018 and 2020

Proportion of 14- to 22-year-olds with each level of depressive symptoms (PHQ-8, score of 0 to 24):	Teens, age 14 to 17		Young adults, age 18 to 22	
	2018 (n = 620)	2020 (n = 789)	2018 (n = 714)	2020 (n = 703)
None (0 to 4)	**67%[a]**	**50%[b]**	**40%[a]**	**27%[b]**
Mild (5 to 9)	**20%[a]**	**26%[b]**	**27%**	**25%**
Moderate to severe (10 to 24)	**13%[a]**	**25%[b]**	**34%[a]**	**48%[b]**
• Moderate (10 to 14)	9%[a]	14%[b]	23%[a]	31%[b]
• Moderately severe (15 to 19)	3%[a]	6%[b]	7%[a]	12%[b]
• Severe (20 to 24)	1%[a]	5%[b]	5%	6%

TABLES 6 AND 7:
Notes: Items may not sum exactly due to rounding. Items with different superscripts differ significantly across rows within each category ($p < .05$).

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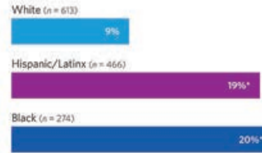
Direct and indirect impacts from COVID-19. As of the time period in which this survey was conducted, from September to November 2020, many U.S. teens and young adults had already been affected by the coronavirus pandemic: One in seven (14%) said they or a family member had gotten sick from the virus, and one in four (25%) said they or a family member had lost their job or income due to COVID-19. Black and Hispanic/Latinx young people were twice as likely as their White peers to say that they or a family member had gotten sick with the virus (20% and 19% vs. 9%).

FIGURE 1. COVID-19 infections in the family, by race/ethnicity, 2020

Percent of 14- to 22-year-olds who say they or a family member have gotten ill from the virus



*Significantly higher than among White youth, at the level of $p < .05$.

TABLE 8. COVID-19-related impacts, by age, gender, and race/ethnicity, 2020

	All	Age		Gender		Race/Ethnicity		
Among 14- to 22-year-olds, percent who have experienced the following during the coronavirus pandemic:	(N = 1,513)	**14 to 17** (n = 796)	**18 to 22** (n = 717)	**Male** (n = 695)	**Female** (n = 778)	**White** (n = 613)	**Black** (n = 274)	**Hispanic/ Latinx** (n = 466)
In-person school was cancelled due to the coronavirus pandemic	55%	66%[a]	46%[b]	51%[a]	59%[b]	58%[a]	43%[b]	54%[a]
Have gotten more sleep	42%	46%[a]	39%[b]	40%	44%	40%	41%	45%
Have felt emotionally closer to their family members	29%	35%[a]	24%[b]	24%[a]	34%[b]	26%[a]	27%[ab]	33%[b]
Have gotten more exercise	28%	31%	25%	29%	27%	28%	26%	28%
Have felt less anxious with no school and other activities	26%	30%[a]	22%[b]	22%	28%	26%	24%	25%
They or a family member have lost a job or income due to the coronavirus	25%	22%[a]	28%[b]	20%[a]	29%[b]	24%	26%	26%
Have had to take on more family responsibilities due to the coronavirus, such as getting a job or taking care of children	18%	17%	18%	17%	18%	14%[a]	13%[a]	24%[b]
Haven't been able to get needed physical or mental health care due to the coronavirus	15%	11%[a]	18%[b]	13%	15%	15%	11%	14%
Household has become more crowded due to the coronavirus	14%	13%	15%	14%	15%	16%[a]	6%[b]	10%[b]
Have been separated from their family due to the coronavirus	14%	12%[a]	17%[b]	12%	17%	13%	13%	17%
They or someone in their family became ill from the coronavirus	14%	16%	13%	13%	15%	9%[a]	20%[b]	19%[b]

Note: Items with different superscripts differ significantly across rows within each demographic category ($p < .05$).

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COVID-19 and depression. The young people most directly affected by COVID-19—those who say that they themselves or someone in their family have gotten ill from the virus—are significantly more likely to manifest moderate to severe symptoms of depression than those who have not been affected in this way. Fully half (51%) of all 14- to 22-year-olds with a family member who became sick with COVID-19 exhibit moderate to severe symptoms of depression, compared to 36% of others in their age group.

TABLE 9. Depressive symptom levels, by COVID-19 infections in family, 2020

Proportion of 14- to 22-year-olds with each depressive symptom level (PHQ-8, score of 0 to 24)	COVID-19 infection in the family	
	No (n = 1,280)	Yes (n = 212)
None (0 to 4)	**38%[a]**	**26%[b]**
Mild (5 to 9)	**26%**	**22%**
Moderate to severe (10 to 24)	**36%[a]**	**51%[b]**
• Moderate (10 to 14)	23%	25%
• Moderately severe (15 to 19)	8%[a]	16%[b]
• Severe (20 to 24)	4%[a]	11%[b]

Notes: Items may not sum exactly due to rounding. Items with different superscripts differ significantly across rows ($p < .05$).

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DIGITAL HEALTH PRACTICES AMONG YOUNG PEOPLE WITH DEPRESSION

A PARTICULAR CONCERN OF this research team has been to explore the use of digital health tools by the large—and growing—proportion of young people who are experiencing depression. In this section, we document the degree to which 14- to 22-year-olds with moderate to severe depressive symptoms, as defined by the PHQ-8 scale (Kroenke et al., 2009), use an array of digital health resources. We also explore how their practices compare with those who do not have depressive symptoms, and whether their use of digital health tools has changed over the past two years.

Digital health activity is more common among teens and young adults with depression than among other people their age. Fully 86% have gone online to look for health information, three out of four (75%) have used mobile apps related to health, nearly six in 10 (58%) have connected with health providers online, and more than half (51%) have tried to find people online with health concerns similar to their own (see Table 10). They are far more likely than young people without depressive symptoms to have connected with providers online (58% vs. 37%) and to have tried to connect online with others facing similar health concerns (51% vs. 28%).

Health information searches. Aside from COVID-19, the top health issues researched online by those with depression are anxiety (55%), depression (53%), and stress (51%) (see Table 11). There are clear and substantial differences between those with moderate to severe depression and those without depressive symptoms in terms of the topics they look up online. For example, there is a difference of 36 percentage points between the two groups in searching for information on depression, a 34-point gap on

TABLE 11. Health information searches, by topic and depressive symptom levels, 2020

Among 14- to 22-year-olds, percent who have searched online for information about ...	Depressive symptoms	
	None (n = 643)	Moderate to severe (n = 510)
COVID-19	54%	55%
Anxiety	21%[a]	55%[b]
Depression	17%[a]	53%[b]
Stress	24%[a]	51%[b]
Fitness and exercise	44%	46%
Diet and nutrition	30%[a]	40%[b]
Sleep disorders	15%[a]	36%[b]
Smoking or vaping	17%[a]	30%[b]
Eating disorders	9%[a]	26%[b]
Birth control	14%[a]	26%[b]
Drug or alcohol abuse	11%[a]	25%[b]
Sexually transmitted diseases	13%[a]	24%[b]
Pregnancy	13%[a]	22%[b]
Cancer	13%	18%
Diabetes	9%[a]	14%[b]
Heart disease	5%[a]	9%[b]
Any other mental health issue	2%[a]	14%[b]
Any other physical health issue	6%	6%
Any health topic	**79%[a]**	**86%[b]**

TABLE 10. Online health resource use, by depressive symptom levels, 2020

Percent of 14- to 22-year-olds who say they have ...	Level of depressive symptoms		
	None (n = 643)	Mild (n = 339)	Moderate to severe (n = 510)
Gone online for health information	80%[a]	91%[b]	86%[b]
Used mobile apps related to health	61%[a]	73%[b]	75%[b]
Connected to health providers online	37%[a]	46%[b]	58%[c]
Looked for people with similar health concerns online	28%[a]	39%[b]	51%[c]

TABLES 10 AND 11: Items with different superscripts differ significantly across rows ($p < .05$).

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anxiety, and a 27-point gap in searches for information about stress. By comparison, we don't find substantial differences on other topics less related to mental health, such as COVID-19 or cancer. Clearly, young people with depression are reaching out for information on their condition online.

While a substantial number of young people with depression are looking for information about their condition online, the proportion who do so has decreased since two years ago: In 2018, 82% of respondents with moderate to severe depressive symptoms had looked for information on either depression, stress, or anxiety, and today 70% have done so. Unfortunately, we can't tell from this survey why they are less likely to look for such information online today, but in reading young people's experiences in their own words, it is clear that the need for online resources on mental well-being remains strong.

For example, when we asked respondents to give us an example of a time they went online to get health information about depression, stress, or anxiety, many were seeking information to better understand or help with a friend or family member's situation. Another significant group needed quick advice for an acute situation, like the anxiety provoked by a big interview or exam. Young people also go online for screening tools, and often that prompts them to seek help offline.

"I looked up how to know if you're depressed. I had been thinking I was depressed for a long while (a couple years). I wanted to make sure that I was before I saw a doctor. I took a quiz, and it said yes, I was and should seek immediate help. I ended up seeing a doctor a couple days later and got help."

—22-year-old woman

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Here are quotes illustrating some of the benefits young people derive from using online resources:

"Just wondering why I get sad or mad for no reason sometimes. I found out that it happens to a lot of people. I'm not the only one."

—15-year-old boy

"I was experiencing symptoms of anxiety, and I wanted to confirm. I found what I was looking for, and it definitely helped me seek therapy I needed."

—16-year-old girl

"I went online to find out about depression because I was going through a hard time, and I found out that other people have gone through this also and gave me a few good ideas about exercising and meditating and talking to my parents about it and it did help."
(In a later response, he wrote: "I went online to find other people who have similar problems with depression, and it helped me realize that there were other people with similar problems. And I made a new friend who I talk with now frequently.")

—16-year-old boy

"Every night I would cry really bad and I wasn't happy, so I looked up depression to [see] if it describes what I'm going through. It helped so I was able to change my life around a little and explain to others what was wrong with me."

—20-year-old woman

"I was stressed and felt like I needed an objective view. Online I was able to find a teenager helpline. It gave me comfort knowing there was someone to talk to besides my mom."

—17-year-old boy

"I went online when my dad left. I was stressed. I still am, but it is not as bad as it was. I didn't know if I needed medication or what. I found some stuff. It helped me. Just knowing that my feelings were normal and that I wasn't crazy and that it would get better."

—17-year-old girl

"I just wanted to see how other people dealt with their stress, especially with school and how they balance it all. It helped me to see that I wasn't alone in my anxiety, and that there are better ways to deal with anxiety rather than just pushing it to the back burner."

—17-year-old girl

"When the virus became a big deal, I looked online to better understand ways to deal with anxiety. I found some good relaxing techniques that helped me calm down."

—21-year-old man

Not everyone finds what they need—or likes what they find:

"Friend tried to commit suicide, and I was wonder[ing] what I could have done to help. No, it didn't [help]."

—14-year-old boy

"Lots of conflicting details ... made me more confused and no specific answers."

—14-year-old boy

"I wanted to not be as scared to go out with people, and no, it did not help."

—15-year-old girl

"I have been stressed and anxious recently and looked up remedies. They did not help."

—17-year-old girl

"I go online to research things and usually make myself worry more."

—17-year-old boy

"Online didn't seem to help. I got the help I needed from close family members being there for me."

—21-year-old woman

"I did find what I was looking for, but it scared me to death."

—21-year-old woman

The stories shared by respondents with moderate to severe depression reflect their overall positive impression of telehealth:

"During quarantine, I was given the opportunity to meet with a therapist via phone call, which helped me out a lot."

—18-year-old woman

"Connecting with my health provider was helpful because they informed me that what was happening was normal. [A]lthough there was nothing that could stop it, knowing it wasn't going to hurt me helped."

—19-year-old woman

However, negative comments also came through in the open-end responses:

"They could not truly see how I felt and properly diagnose me."

—17-year-old girl

"Basically was told to call again another time and they couldn't help me with anything. Waste of $60."

—17-year-old nonbinary person

Mobile apps related to mental health. More than a third of young people with moderate to severe depressive symptoms (36%) say they have used apps related to sleep (see Table 12). Nearly one in four (24%) have tried apps related to stress, and one in five (21%) have used apps for meditation or mindfulness. All told, nearly half (46%) of young people with moderate to severe depressive symptoms have used mobile apps related to their mental well-being (up from 38% in 2018); this is more than twice the proportion of young people without depression who have tried apps on these topics (19%).

Connecting with health providers online. Given that this survey was conducted during the coronavirus pandemic, it is perhaps not surprising that many young people with depression were taking advantage of online ways of connecting to health providers (see Table 13). Nearly six in 10 (58%) young people with moderate to severe depression have connected with a health provider online, primarily through video appointments (33%), but also by text (20%), with an online message system (21%), or through an app (18%).

Young people with depression who haven't yet connected with a provider online express more interest in doing so than others their age (52% are interested, compared to 40% of those who are not depressed; see Table 14 on page 28). Among young people with depression who have connected with a provider online, the vast majority (79%) say that doing so was "very" (34%) or "somewhat" (46%) helpful. However, despite their interest and desire to connect, they have significantly lower satisfaction with telehealth than their nondepressed peers: 79% of those who have connected with a provider online say they are very or somewhat satisfied with the experience, compared to 92% of those without depression.

All methods of connecting with providers online have increased since two years ago among those with depression. Unfortunately, we cannot be sure whether the apparent increase in video connections is due in part to a change in questionnaire wording (from "video chat" to "video appointment").

"I miss the in-person connection with the provider, but the virtual appointment still gets the job done."

—18-year-old man

TABLE 12. Health-related mobile app use, by degree of depressive symptoms, 2020

Among 14- to 22-year-olds, percent who have used a mobile app related to ...	Depressive symptoms	
	None ($n = 643$)	Moderate to severe ($n = 510$)
Sleep	18%[a]	36%[b]
Stress	8%[a]	24%[b]
Meditation/mindfulness	12%[a]	21%[b]
Depression	2%[a]	18%[b]
Mood tracker	5%[a]	17%[b]
Alcohol or drug abuse	1%[a]	6%[b]
Any mental health topic*	**19%[a]**	**46%[b]**

*Includes stress, meditation/mindfulness, depression, mood tracker, and alcohol or drug abuse.

TABLE 13. Connecting with health providers online, among those with depression, 2018 and 2020

Among 14- to 22-year-olds with moderate to severe depressive symptoms, percent who have connected via ...	2018 ($n = 322$)	2020 ($n = 510$)
Video appointment*	8%[a]	33%[b]
Text message	15%[a]	20%[b]
Online message system	11%[a]	21%[b]
An app	9%[a]	18%[b]
Any digital connection	**32%[a]**	**58%[b]**

*In 2018 this item was worded as "video chat." Therefore, changes over time may not be comparable.

TABLES 12 AND 13:
Items with different superscripts differ significantly across rows ($p < .05$).

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TABLE 14. Connecting with health providers online, by degree of depressive symptoms, 2020

Among 14- to 22-year-olds, percent who have connected via ...	Level of depressive symptoms		
	None ($n = 643$)	Mild ($n = 339$)	Moderate to severe ($n = 510$)
Video appointment	23%[a]	24%[a]	33%[b]
Text message	9%[a]	15%[b]	20%[b]
Online message system	7%[a]	10%[a]	21%[b]
An app	7%[a]	11%[ab]	18%[b]
Any digital connection	**37%[a]**	**46%[b]**	**59%[c]**
Among those who have connected with a provider online, percent who say it was very/somewhat helpful	**92%[a]**	**92%[a]**	**79%[b]**
Among those who have not connected with a provider online, percent who are interested in connecting digitally	**40%[a]**	**47%[ab]**	**52%[b]**

Note: Items with different superscripts differ significantly across rows ($p < .05$).

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SOCIAL MEDIA AND DEPRESSION AMONG TEENS AND YOUNG ADULTS

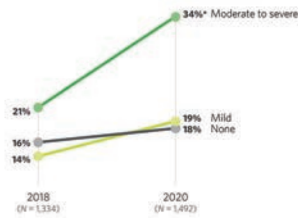
IN THIS SECTION OF the report, we explore the role of social media in young people's lives, with a special focus on those living with depression. We look at the frequency of their use of social media, and its importance to them across a variety of realms including creative expression, inspiration, feeling less alone, and getting support and advice from others. We also listen to young people's perspectives about how using social media makes them feel when they are already feeling depressed, stressed, or anxious.

Frequency of social media use. Not surprisingly, almost all (95%) young people say they use social media (see Table 15). Over the past two years, the frequency of social media use has crept up. Today one in four (25%) 14- to 22-year-olds say they are on social media "almost constantly," an increase of eight percentage points since 2018. Whether this is a permanent increase or an artifact of being stuck inside during the pandemic, only future research will tell.

Relationship between depression and frequency of social media use. Those suffering from moderate to severe depressive symptoms are nearly twice as likely as those without depression to say they use social media almost constantly (34% vs. 18%, see Figure 2). Therefore, in this survey we do see a relationship between social media use and depression, although it is not possible to know if there is a causal relationship between these two measures, and if so, in which direction it runs.

FIGURE 2. "Almost constant" use of social media, by level of depressive symptoms, 2018 and 2020

Percent of 14- to 22-year-olds who say they use social media "almost constantly"



*Significantly higher than 2018 at the level of $p < .05$.

TABLE 15. Frequency of social media use, by year of data collection, and by degree of depressive symptoms in 2020

Percent of 14- to 22-year-olds who say they use social media ...	Data collection		Level of depressive symptoms		
	2018 (N = 1,337)	2020 (N = 1,513)	None (n = 643)	Mild (n = 339)	Moderate to severe (n = 510)
• Almost constantly	17%[a]	25%[b]	18%[a]	19%[a]	34%[b]
• Daily but not constantly	64%[a]	56%[b]	64%[a]	64%[a]	44%[b]
• *Multiple times a day*	*54%[a]*	*48%[b]*	*55%[a]*	*58%[a]*	*36%[b]*
• *Once a day*	*10%[a]*	*8%[b]*	*9%*	*6%*	*8%*
• Less than daily	11%[a]	15%[b]	13%	12%	18%
• *Weekly*	*9%*	*11%*	*2%[a]*	*1%[a]*	*5%[b]*
• *Less than weekly*	*2%[a]*	*4%[b]*	*4%*	*4%*	*3%*
• Never	7%[a]	5%[b]	5%	5%	4%
Use social media	**93%[a]**	**95%[b]**	**95%**	**95%**	**95%**

Note: Items with different superscripts differ significantly across rows ($p < .05$).

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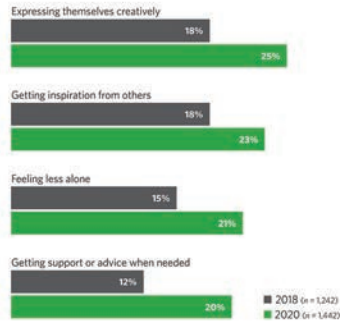
It is particularly intriguing that the increase in social media use between 2018 and 2020 has been almost entirely among those who are currently displaying symptoms of depression (the surveys were not longitudinal—separate cross-sectional samples were taken in each wave). It may be that as social media use increased, those who used it more frequently began experiencing greater levels of depression. But based on the totality of our findings, it appears equally possible that as more young people began experiencing symptoms of depression (whatever the cause) they also began turning to the internet and social media for help.

Importance of social media. While some may dismiss young people's social media use as nothing more than the posting of selfies and a venue for gossip and celebrity tracking, it is clear that social media also fills important functions, perhaps especially during this time of isolation due to the coronavirus pandemic. At least one in five teens and young adults say that social media is "very" important to them for expressing themselves creatively (25%), getting inspiration from others (23%), feeling less alone (21%), and getting support or advice when needed (20%). Young people are significantly more likely to say social media is "very" important to them for these purposes today than they were in 2018 (see Figure 3). For example, the percent saying that social media is very important for getting support or advice is up by eight percentage points, from 12% to 20%; and the percent saying social media is very important for creative expression is up by seven percentage points, from 18% to 25%. We can't know at this point whether this is a permanent increase in social media's importance or a function of the coronavirus pandemic.

Importance of social media for those with depression. Social media plays an outsized role in the lives of teens and young adults who have depression. These young people are significantly more likely than their peers to say that social media is "very" important to them for all the reasons cited above (see Table 16). For example,

FIGURE 3. Importance of social media, among all social media users, 2018 and 2020

Percent of 14- to 22-year-old social media users who say social media is "very" important to them for ...



Note: Differences between 2018 and 2020 are statistically significant at the level of $p < .05$.

TABLE 16. Importance of social media, by depressive symptom levels, 2020

Percent of 14- to 22-year-old social media users who say social media is "very" important to them for ...	All (n = 1,442)	Level of depressive symptoms		
		None (n = 609)	Mild (n = 317)	Moderate to severe (n = 496)
Getting support/advice when needed	20%	15%[a]	19%[ab]	26%[b]
Expressing themselves creatively	25%	20%[a]	27%[ab]	27%[b]
Getting inspiration from others	23%	17%[a]	20%[a]	29%[b]
Feeling less alone	21%	13%[a]	20%[b]	28%[c]

Note: Items with different superscripts differ significantly across rows ($p < .05$).

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28% of those with moderate to severe depressive symptoms say social media is "very" important for feeling less alone, compared to 13% of those without depression.

In fact, the increase in the importance of social media in young people's lives has occurred primarily among those with depression. For example, the proportion of young people with depression who say social media is "very" important for getting support or advice when they need it has more than doubled over the past two years, up from 11% in 2018 to 26% today. (For those without depression, the change has been from 11% to 15%, not a statistically significant difference; see Figure 4.) It is possible that the efforts of providers and peers to provide support have improved, and therefore that there is more supportive content today.

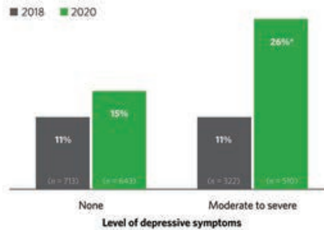
How social media makes young people feel when they are depressed, stressed, or anxious. Many adults are concerned that using social media may make teens and young adults feel worse about themselves, especially for those who are already feeling depressed, stressed, or anxious. There are any number of reasons why this could be the case; for example, comparing oneself to others who may seem more popular or attractive, or being on the receiving end of more frequent and visible negative feedback (Odgers & Robb, 2020). But there are also reasons to suppose that using social media could help young people feel *better* when they are feeling poorly, such as getting support from their friends, inspiration from others who have gone through similar situations, or simply distracting themselves with humorous or relaxing content.

We asked all young people in the survey how using social media affects them when they are feeling depressed, stressed, or anxious. (This was asked of all respondents, not just those with high PHQ-8 scores, on the assumption that everyone has such feelings once in a while.) Overall, young people are far more likely to say that using social media makes them feel better (43%) rather than worse (17%). The rest say it makes no difference either way. Since 2018, the number of young people who say social media helps them feel better during such times has grown substantially (see Figure 5): Two years ago, 27% said it made them feel better, while 43% say so now.

It is quite striking that such a large proportion say social media helps them to feel better during difficult periods. We asked respondents to share an example of how they used social media during such times, and how it made them feel (see page 32 for survey responses).

FIGURE 4. Importance of social media for support and advice, by depressive symptom levels, 2018 and 2020

Among 14- to 22-year-olds, percent who say social media is "very" important to them for getting support and advice



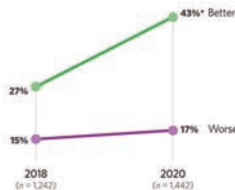
*Significantly higher than 2018 at the level of $p < .05$.

"I had been stressed out and quarantining because of COVID-19. I was suffering from extreme anxiety and depression due to the isolation and homeschooling."

—17-year-old boy

FIGURE 5. Effect of social media when feeling depressed, stressed, or anxious, 2018 and 2020

Among 14- to 22-year-old social media users, percent who say using social media when they are depressed, stressed, or anxious usually makes them feel ...



*Significantly higher than 2018 at the level of $p < .05$.

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Here is a sample of those who shared stories about the positive effects of social media:

"Social media has made me feel less depressed because I have been able to make new online friends. I have started a small business through social media during the pandemic and have been able to communicate with customers and other small business owners very easily."

—16-year-old girl

"I was able to keep in touch with my friends, [and] we could game together online or watch TV shows or movies together online, so it was almost like hanging out with them in person."

—17-year-old boy

"I use Discord, Twitter, Snapchat, and Instagram to talk to friends, share my art with others, and see my friend's art and other projects."

—19-year-old woman

"It helps to talk to other kids who are feeling the same kind of isolation from doing school remotely and basically having everything change about our high school experience as seniors this year."

—17-year-old girl

"Social media has made me feel less depressed during the coronavirus pandemic because I was able to follow inspirational accounts and connect with friends that I could not see in person. Of course, video chats helped a lot as well."

—18-year-old woman

On the other hand, some young people felt that social media had a negative effect on their mood:

"Having a constant stream of negative news directly to your phone is bound to have a negative impact on mood and outlook. It makes me concerned for my health and future. For me, though, it is more about the local social element of social media. It can make you feel isolated and alone from everyone else."

—16-year-old boy

"The constant barrage about deaths and other travesties that are happening across the country and the world is exhausting. I scroll through Instagram, [and] I learn about people dying in the Middle East. I'm reminded of the wildfires that are consuming the West Coast. I see every issue in the world, and I am literally just on my phone, helpless to fix any of them. Social media connects you to the world, but it also has connected me to the world's problems, which have started to feel like my own."

—16-year-old boy

"I am tired of hearing about all of the political junk and the pandemic, and it makes me wish the state of the world would be better."

—19-year-old woman

"I saw mostly just celebrities who could afford to do whatever they wanted with their time in quarantine, and that greatly depressed me since I was struggling to pay my bills/manage small children in my household for months."

—21-year-old woman

The severely depressed. There is reason to believe that for those young people experiencing the most serious episodes of depression, social media may pose greater concerns. The number of respondents in this survey who indicate symptoms of "severe" depression is, thankfully, quite low (about 5%, or one in 20), which means that findings among this small group should be viewed with caution. However, there appear to be clear indications that for those who have severe depression, social media plays an outsized role—more important for inspiration, support, and connection, but also more likely to make respondents more anxious, lonely, and depressed. One thing that can be missed when lumping these "severely" depressed young people into the broader category of "moderate to severe" depression is how steep the differences are for some items, based on the degree of depression. The small sample size means that we can't draw firm conclusions about the effects of social media on young people with severe depression, but we do think the findings are worth highlighting here for further exploration in future research.

One example is the frequency of social media use. As reported above, 34% of young people in the moderate to severe depression group say they are on social media "almost constantly" (see Figure 6). But this rate increases from 31% of those in the "moderate" category and 30% of those in the "moderately severe" group, up to 56% of the "severely" depressed respondents. This high rate of social media use by the most depressed young people seems worth special consideration.

Similarly, the proportion of teens and young adults who say social media is "very" important to them across a variety of realms also rises steeply among the most highly depressed (see Figure 7). It

FIGURE 6. "Almost constant" use of social media, by three and five depressive symptom levels, 2020

Percent of 14- to 22-year-olds who say they use social media "almost constantly"

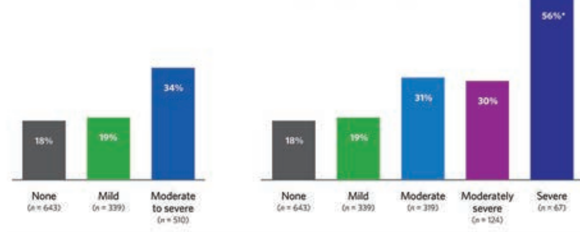
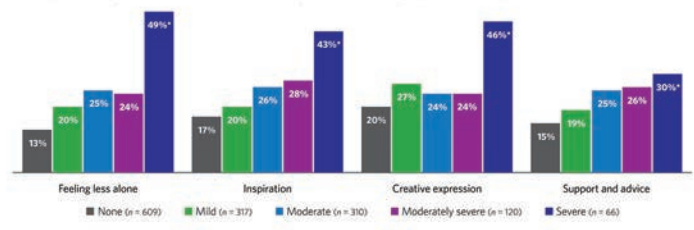


FIGURE 7. Importance of social media, by five depressive symptom levels, 2020

Percent of 14- to 22-year-old social media users who say "social media is very important to me for ..."



FIGURES 6 AND 7:
*Results among the "severe" group should be interpreted with extreme caution due to the small sample size.

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is also worth noting the high proportion of respondents among the severely depressed group who say that using social media during the coronavirus pandemic has made them feel more anxious, depressed, and lonely (see Figure 8 and the quotes below).

Those with the highest levels of depression are much more likely to have used online health resources about their condition. Nearly two-thirds (62%) of those with severe depression say they have tried to find people online with the same health concerns. As one 19-year-old man wrote, "I just went out looking for people that are in the same position I am, and we were able to connect and understand that we weren't alone like we thought we were." Another respondent with severe depression, age 22, shared, "My brother had been diagnosed with anxiety and when he mentioned his symptoms, I realized I had the same ones constantly. I never went to the doctor to check it out, but online, I saw it as a possibility."

More than three out of four (76%) young people reporting symptoms of severe depression have searched for information about depression online. When asked to share an example of a time they looked online for information about emotional well-being, one 18-year-old woman wrote, "I self-diagnosed myself with depression and anxiety, and it did help because I went to the doctor to get medicine." And a 19-year-old man shared, "When I was first diagnosed with depression and anxiety, I wanted to learn more. I did find what I was looking for. It helped because then I was able to talk to my therapist more about it with a better understanding." Not everyone found what they needed. As a 20-year-old nonbinary person wrote, "I have a mix of all three [depression, stress, anxiety], and it affects my personal life. I did not find what I was looking for, and it did not help."

This survey shows that online health resources and social media are being used extensively by teens and young adults most profoundly affected by depression, and that social media plays a decidedly complex role in their lives, offering connection and support as well as—for some—contributing to their anxiety and depression. Clearly, whether we're considering the positive or the negative role of digital media use in young people's lives, those who are most severely depressed deserve special consideration. Adults should approach the issue of social media use among this population carefully.

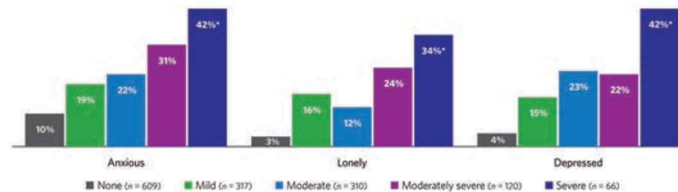
Not surprisingly, people in this group shared colorful and intense responses to our question related to social media's role in making them feel more or less depressed during the coronavirus pandemic.

"It's made me feel more depressed because I look at people doing stuff, and realize all I do all day is play Minecraft, and I think about how I could do actual stuff, but I still just play Minecraft instead."

—15-year-old boy

FIGURE 8. Effect of social media on user's anxiety, loneliness, and depression, by five depressive levels, 2020

Percent of 14- to 22-year-old social media users who say using social media during the pandemic has made them feel more ...



*Results among the "severe" group should be interpreted with extreme caution due to the small sample size.

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On the positive side, here are some comments from respondents with severe depression:

"I'm able to connect with my friends still which is what I need the most. I hate being alone."

—15-year-old girl

"It has things that inspire me to be more creative, it makes me feel less alone when I am, funny things lift my mood and make me happier when I'm upset."

—16-year-old girl

"It makes me feel more connected to people when I can't see them due to social distancing."

—18-year-old woman

"There will be times when quarantine made me depressed and a funny video on Instagram or TikTok helped lighten my mood."

—19-year-old woman

"I was able to see positive posts that people put up. I was also able to stay in contact with my friends."

—22-year-old woman

On the negative side:

"I feel like I don't matter and I'm losing myself."

—14-year-old girl

"The world is going to crash and burn."

—14-year-old girl

"Seeing those who do not social distance both makes me mad and makes me lonely because I will not risk my family's health to hang out with my friends."

—17-year-old girl

"I'm lonely all the time. Can't go anywhere or do anything. I didn't have friends even before, but now it's worse considering the pandemic. I get sad a lot."

—19-year-old woman

"Right now, the world is at a point of no return. No matter what anyone does, nothing will ever get better."

—19-year-old man

"There are people out there that are seemingly having a great time most of the time, leaving me in my brain wishing people would just understand what a pandemic really is."

—20-year-old man

SOCIAL MEDIA IN TROUBLED TIMES: THE CORONAVIRUS PANDEMIC AND ONLINE HATE

THE SURVEY ALSO ASKED young people about using social media during the coronavirus pandemic in particular, including how important social media has been to them for being informed about current events, learning how to protect themselves against the virus, and staying connected to family and friends.

Not surprisingly, more than half (53%) of all respondents said that during the coronavirus pandemic, social media has been "very" important for staying connected to friends and family members (see Figure 9). About a third say social media has been "very" important as a way of being informed about current events (34%) and for learning how to protect themselves against the virus (31%).

Because the survey included a series of questions about how respondents have been affected by COVID-19, we are able to look at the importance of social media during the pandemic for those who have been most directly affected. One in seven respondents said that either they or a family member had become ill from the coronavirus (as of early fall 2020). For these young people, social media has played an even more important role in helping them stay informed about current events and learn how to protect themselves against the virus. More than four in 10 said social media has been "very" important for these purposes (see Table 17). When compared to their peers, it is clear that social media has played a significant role in helping those who have been directly impacted by COVID-19.

FIGURE 9. Importance of social media during the coronavirus pandemic, 2020

Among 14- to 22-year-old social media users (n = 1,442), percent who say using social media during the pandemic has been important to them for ...

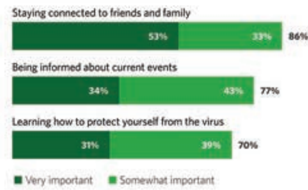

TABLE 17. Importance of social media during the coronavirus pandemic, by COVID-19 infections in the family, 2020

Among 14- to 22-year-old social media users, percent who say using social media during the coronavirus pandemic has been "very" important to them for ...	COVID-19 infection in the family	
	No (n = 1,294)	Yes (n = 219)
Being informed about current events	32%[a]	47%[b]
Learning how to protect themselves against the virus	29%[a]	43%[b]
Staying connected to family and friends	53%	57%

Note: Items with different superscripts differ significantly across rows, across status of COVID-19 infection in family ($p < .05$).

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The survey also explored the impact of social media on young people's emotional health specifically during the pandemic. Some respondents noted that the barrage of negative news online made them even more anxious or depressed (see Figure 10). But respondents overall were more likely to say that using social media during the pandemic actually made them feel less anxious (28% vs. 19% who said more) and less depressed (25% vs. 15% who said more). And they were overwhelmingly more likely to say it helped them feel less lonely during this time (41% vs. 12% who said more).

Hate speech and social media. While exposure to hate speech online is certainly not a new phenomenon, in 2020 the amount of vitriol spewed on social media felt overwhelming at times. In an effort to document young people's exposure to such content, this year's survey included measures of how often they come across various types of hate speech on social media.

About one in four young people say they "often" encounter racist, sexist, homophobic, or body shaming comments in the social media they use (see Figure 11). Sadly, but not surprisingly, the teens and young adults who are most likely to be affected by such content are most likely to encounter it—or recognize and remember it. For example, Black young people are more likely than Whites to say they "often" see racist comments (34% vs. 23%), LGBTQ+ youth are far more likely than non-LGBTQ+ youth to encounter homophobic comments (44% vs. 18%), and female young people are more likely to encounter sexist (30% vs. 21%) and body shaming (35% vs. 23%) social media posts than males. The fact that three in 10 young women often encounter sexist comments, more than a third of young Black people often encounter racist comments, and more than four in 10 LGBTQ+ youth often encounter homophobic posts online is a sad commentary on the state of social media today.

Our findings indicate that the frequency with which young people encountered hate speech on social media in 2020 was substantially higher than it was just two years earlier. Questions about hate speech in social media were included in a 2018 Common Sense Media survey of teens (Rideout & Robb, 2018), so we are able to compare results for 14- to 17-year-olds between 2018 and 2020. In 2018, 12% of 14- to 17-year-olds said they often came across racist comments on social media; in the current survey, that rate has nearly doubled to 23% (see Figure 12). The proportion of teens who say they often come across homophobic content has gone from 13% in 2018 to 21% today, and for sexist content the rate has gone from 15% to 21%.

FIGURE 10. Effect of social media on mental health, 2020

Among 14- to 22-year-old social media users (n = 1,442), percent who say using social media during the coronavirus pandemic makes them feel "more" or "less" ...

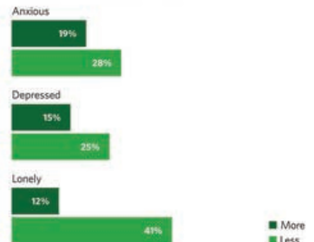


FIGURE 11. Exposure to hate speech on social media, 2020

Among 14- to 22-year-old social media users (n = 1,442), percent who say they encounter each type of content

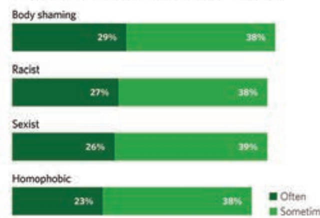
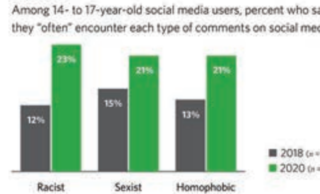


FIGURE 12. Exposure to hate speech on social media, 2018 and 2020

Among 14- to 17-year-old social media users, percent who say they "often" encounter each type of comments on social media



Note: 2018 trend data from the Common Sense Media survey *Social media, social life: Teens reveal their experiences*, conducted among 14- to 17-year-olds. Differences between 2018 and 2020 in each category are statistically significant at the level of $p < .05$.

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DIGITAL HEALTH, SOCIAL MEDIA, AND PROBLEMATIC SUBSTANCE USE

IN THIS SURVEY, THE CRAFFT screener was used to identify young people at risk for problematic substance use. CRAFFT is a validated screening tool designed for use with young people age 12 to 21 to help providers identify patients in need of counseling or other interventions (Knight et al., 2002). In analyzing the survey findings, we used respondents' age-adjusted CRAFFT scores to compare the digital health and social media behaviors of those at risk for problematic substance use to those not at risk. This survey is not intended as a comprehensive assessment or analysis of the extent and severity of substance use problems among teens and young adults, nor is it designed to explore any causal relationships. Rather, the purpose of conducting these analyses is to better understand the online health behaviors of young people most at risk for problematic substance use.

Based on this screener, 9% of respondents were identified as "at risk" for problematic substance use. In this section of the report, we take a closer look at the digital health and social media practices of these young people. Are they in fact seeking relevant information online, using relevant apps, and connecting to providers through telehealth? And is their social media use different than others their age?

Digital health use. The findings indicate that many young people at risk for substance use problems are seeking out online health resources on relevant topics. These youth are more likely than their peers to have engaged in a number of online health-seeking activities, including looking up information on drug and alcohol abuse, trying to find others online with similar health conditions, and using digital tools to connect to providers. These data clearly indicate that young people at risk for substance use problems are turning to the internet for relevant information and support (see Table 18).

Online health information. Aside from COVID-19, the health issues young people at risk for problematic substance use are most likely to have investigated online include depression (66%), anxiety (57%), and stress (58%) (see Table 19). More than four in 10 (46%) have searched for information about substance use problems online, compared to just 15% of their peers. Providers or advocates wishing to reach young people at risk of substance use problems could target any of those topic areas with related content.

TABLE 18. Digital health use, by risk for problematic substance use, 2020

Among 14- to 22-year-olds, percent who have ...	Risk of problematic substance use	
	No (n = 1,358)	Yes (n = 143)
Looked up online information about drug and alcohol abuse	15%[a]	46%[b]
Tried to find others online with the same health issues	38%[a]	57%[b]
Connected with health providers online	46%[a]	60%[b]
Used a mobile app related to drug and alcohol abuse	2%[a]	13%[b]

TABLE 19. Top online health information searches, by risk for problematic substance use, 2020

Among 14- to 22-year-olds, percent who have searched online for information about ...	Risk of problematic substance use	
	No (n = 1,358)	Yes (n = 143)
Depression	35%[a]	66%[b]
COVID-19	57%	62%
Anxiety	40%[a]	57%[b]
Stress	36%[a]	58%[b]
Smoking or vaping	19%[a]	63%[b]
Fitness and exercise	46%	52%
Diet and nutrition	37%	43%
Sleep disorders	23%[a]	46%[b]
Alcohol or drug abuse	15%[a]	46%[b]
Sexually transmitted diseases	16%[a]	41%[b]

TABLES 18 AND 19:
Note: Items with different superscripts differ significantly across rows ($p < .05$).

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Mobile apps for health. Thirteen percent of young people at risk for problematic substance use say they have tried mobile apps directly related to drug and alcohol abuse (see Table 20). Much larger proportions have used apps on other health topics, including fitness (42%), sleep (41%), meditation (27%), and stress reduction (28%). Incorporating relevant messaging on drugs and alcohol into apps on these other topics may be an effective way to reach at-risk youth.

Telehealth. More than two in five (41%) young people at risk for problematic substance use have had a video appointment with a health provider, while others have connected to providers via an online messaging system (27%), text (17%), an app (15%) or some other means (3%). Of those who have engaged in some form of telehealth, the vast majority (81%) say it was either very (41%) or somewhat (40%) helpful. Of those who have not yet connected with a provider online, a majority (54%) are at least somewhat interested in doing so (11% are very interested, 44% somewhat).

Social media use. Social media consumes a great deal of attention from those teens and young adults at risk for problematic substance use, with 37% saying they use it "almost constantly" (compared to 24% for those without substance use issues). Unfortunately, when they are feeling depressed, stressed, or anxious, using social media is not as likely to have a positive effect as it is for other young people for whom substance use is not an issue. Thirty-five percent of those at risk for problematic substance use say using social media at such times makes them feel worse, compared with just 15% of those without substance issues (see Table 21).

"A friend of mine started having alcohol abuse issues that began to affect him at work. He started missing work so much they actually fired him. I found what I was looking for online, but my friend didn't want my help."

—18-year-old man

TABLE 20. Health-related mobile app use, among those at risk for problematic substance use, 2020

Among 14- to 22-year-olds, percent who have ever used a mobile app related to ...	Risk of problematic substance use	
	No (n = 1,358)	Yes (n = 143)
Fitness	39%	42%
Sleep	25%[a]	41%[b]
Period/menstruation	23%[a]	35%[b]
Nutrition	22%[a]	32%[b]
Meditation/mindfulness	16%[a]	27%[b]
Stress reduction	12%[a]	28%[b]
Depression	8%[a]	21%[b]
Mood tracker	9%[a]	19%[b]
Medication reminder	6%[a]	16%[b]
Birth control	6%[a]	11%[b]
Alcohol or drug abuse	2%[a]	13%[b]
Quitting smoking/vaping	2%[a]	8%[b]

Note: Items with different superscripts differ significantly across rows ($p < .05$).

TABLE 21. Effect of social media when depressed, stressed, or anxious, by risk for problematic substance use, 2020

Among 14- to 22-year-old social media users, percent who say using social media when they are depressed, stressed, or anxious usually makes them feel ...	Risk of problematic substance use	
	No (n = 1,319)	Yes (n = 114)
Better	43%	43%
Worse	15%[a]	35%[b]
Neither	42%[a]	22%[b]

Note: Items with different superscripts differ significantly across rows ($p < .05$).

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Young people among the 9% of respondents at risk for problematic substance use described examples of times they had sought online information related to drug or alcohol abuse:

"I did find resources to help combat addiction and withdrawals."

—18-year-old man

"My stepdad at the time was abusing alcohol, and I wanted to find resources to help my family deal with him. I found some information but not much."

—20-year-old woman

"I have known multiple people who have died from overdoses or other drug abuse complications, and know quite a few folks who haven't gone that far into it but want to be able to help if they need."

—22-year-old woman

"Wondering if me or my friends were abusing alcohol. Yes, it helped me clarify what constitutes alcoholism."

—22-year-old woman

Drug and alcohol problems are a concern for lots of teens and young adults, even those not directly at risk themselves. We asked respondents who do not report any signs of problematic substance use to share a time they went online to get information about drug or alcohol abuse and if they found helpful information.

A sample of stories they shared:

"I went on to Google to see the side effects of many drugs, such as marijuana, Percocet, and Xanax. Yes, I found what I was looking for, and [it] helped me understand why taking such drugs isn't so smart and not for me."

—14-year-old boy

"I had a friend that appeared to be addicted to vaping. I looked up information on this possibility. It helped me figure a way to scare her into quitting."

—16-year-old girl

"I have a friend who is a drug user. I wanted to know the negative effects of the drug that she was using. I went online to find information that would help me understand her situation. Having some input on what she was dealing with gave me a new perspective of what she was going through."

—16-year-old girl

"Someone wanted to get treatment and no, I didn't find it."

—19-year-old woman

"I was looking for how to help a friend who is possibly hiding from their problems through the use of drugs and alcohol. Yes, I was able to find what I was looking for. It did not help that much because the friend would not listen to me about their overuse of alcohol."

—18-year-old woman

"I thought my brother was on drugs. Yes, I found everything I needed. Yes, it helped a lot. I got my brother into a rehab to get him off drugs."

—20-year-old man

"Just wanted to learn more about it and how it affects different people. It's a huge crisis in this country, and more has to be done to help anyone suffering from it."

—22-year-old man

"I wanted to know more about it because I found out that my friend was struggling with it and I wanted to help."

—22-year-old man

DIGITAL HEALTH, SOCIAL MEDIA, AND LGBTQ+ YOUTH

SIXTEEN PERCENT OF RESPONDENTS in the survey identified as lesbian, gay, or bisexual, or as transgender or nonbinary. We refer to these respondents as LGBTQ+. In this section of the report, we take a closer look at the use of online health resources and social media among this population, and at issues of mental well-being.

Depression and LGBTQ+ youth. The rate of depression among LGBTQ+ youth is profoundly alarming. Nearly two-thirds (65%) report moderate to severe symptoms of depression, more than twice the rate among non-LGBTQ+ youth (31%) (see Table 22). This is similar to the difference in levels of depression found in 2018 (59% among LGBTQ+ youth vs. 20% among others).

Risk of problematic substance use and LGBTQ+ youth. Based on the CRAFFT screener used in the survey to identify risk of problematic substance use (Knight et al., 2002; Winters & Kaminer, 2008), LGBTQ+ youth are at higher risk than their non-LGBTQ+ peers. About one in five (19%) LGBTQ+ young people are considered at risk, compared to 8% of non-LGBTQ+ youth (see Table 23).

Online health resources and LGBTQ+ youth. Almost all (98%) LGBTQ+ respondents have made use of digital health tools in some form or another, including nine out of 10 (92%) who have looked for health information online, three out of four (75%) who have used a mobile app related to health, and more than half who have connected with health providers online (58%) or tried to find people online with similar health concerns (54%) (see Table 24).

"I am part of a teen depression Facebook group that offers mutual support and lets people post when they need encouragement."

—15-year-old boy

TABLE 22. Depressive levels, by LGBTQ+ identity, 2020

Proportion of 14- to 22-year-olds with each level of depressive symptoms (PHQ-8)	Non-LGBTQ+ (n = 1,166)	LGBTQ+ (n = 243)
None	44%[a]	11%[b]
Mild	25%	24%
Moderate to severe	31%[a]	65%[b]

TABLE 23. Risk for problematic substance use, by LGBTQ+ identity, 2020

Proportion of 14- to 22-year-olds at risk for problematic substance use (CRAFFT screener)	Non-LGBTQ+ (n = 1,174)	LGBTQ+ (n = 246)
Not at risk	92%[a]	81%[b]
At risk	8%[a]	19%[b]

TABLE 24. Online health resource use, by LGBTQ+ identity, 2020

Among 14- to 22-year-olds, percent who say they have ever ...	Non-LGBTQ+ (n = 1,179)	LGBTQ+ (n = 248)
Gone online for health information	84%[a]	92%[b]
Used mobile apps related to health	68%	75%
Connected to health providers online	45%[a]	58%[b]
Looked for people with similar health concerns online	38%[a]	54%[b]
Any of the above	**93%[a]**	**98%[b]**

TABLES 22-24
Note: Items with different superscripts differ significantly across rows ($p < .05$).

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Health information searches. Huge numbers of LGBTQ+ youth are going online to seek information on mental health issues, including 77% on anxiety, depression, and stress alone (compared to 51% of non-LGBTQ+ youth, see Table 25). Forty-three percent have searched for information on sleep disorders (vs. 21% of others), and a third (34%) on eating disorders (vs. 14% of non-LGBTQ+ youth). One in five have searched for information on other mental health issues, compared to 5% of their non-LGBTQ+ peers.

Mobile apps. Nearly three in four (75%) LGBTQ+ youth have used a mobile app related to health promotion (see Table 26 on page 45); the most common type of health app used among this population is for sleep (39% say they have used at least one). App use has increased over the past two years among LGBTQ+ youth on several topics related to mental well-being, including sleep (from 22% to 39%), meditation (from 20% to 30%), stress reduction (from 15% to 28%), and mood trackers (from 11% to 23%) (see Table 27 on page 45).

Telehealth. More than half (58%) of LGBTQ+ youth have connected to health providers online (see Table 28 on page 45), including one in three (34%) who have met with a provider through a video appointment, and one in five who have connected through text messaging (23%) or some other type of online messaging system (19%). It is worth noting that LGBTQ+ youth who have connected to providers online are less satisfied with those experiences than their non-LGBTQ+ peers (see Table 29 on page 45). Twenty-seven percent say it was "very" helpful, compared to 41% of non-LGBTQ+ youth. At the same time, the vast majority report it being at least "somewhat" helpful (a total of 78% say very or somewhat helpful). As with non-LGBTQ+ youth, many of those who haven't yet connected with providers online say they are "somewhat" interested in doing so (43%), although only 12% say they are "very" interested (see Table 30 on page 45).

Connecting to health peers online. Just over half (54%) of LGBTQ+ youth say they have gone online to look for people with similar health concerns as their own (compared to 38% of non-LGBTQ+ youth). This is about the same rate found in 2018 (50%).

TABLE 25. Online health information search topics, by LGBTQ+ identity, 2020

Among 14- to 22-year-olds, percent who have gone online for information about ...	Non-LGBTQ+ (n = 1,179)	LGBTQ+ (n = 248)
COVID-19	57%	63%
Anxiety	36%^{a}	63%^{b}
Depression	32%^{a}	62%^{b}
Stress	35%^{a}	55%^{b}
Fitness and exercise	46%	50%
Diet and nutrition	35%^{a}	48%^{b}
Sleep disorders	21%^{a}	43%^{b}
Eating disorders	14%^{a}	34%^{b}
Birth control	17%^{a}	34%^{b}
Sexually transmitted diseases	16%^{a}	31%^{b}
Smoking or vaping	23%	30%
Pregnancy	16%^{a}	26%^{b}
Drug or alcohol abuse	17%^{a}	27%^{b}
Cancer	15%^{a}	22%^{b}
Diabetes	11%^{a}	16%^{b}
Heart disease	6%^{a}	11%^{b}
Any other mental health issue	5%^{a}	20%^{b}
Any other physical health issue	5%	8%
Depression, stress, or anxiety	**51%^{a}**	**77%^{b}**
Any health topic	**84%^{a}**	**92%^{b}**

Note: Items with different superscripts differ significantly across rows ($p < .05$).

"I was experiencing symptoms of anxiety, and I wanted to confirm. I found what I was looking for and it definitely helped me seek therapy I needed."

—16-year-old girl

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TABLE 26. Health-related mobile app use, by topic and LGBTQ+ identity, 2020

Among 14- to 22-year-olds, percent who have ever used a mobile app related to ...	Non-LGBTQ+ (n = 1,179)	LGBTQ+ (n = 248)
Sleep	24%[a]	39%[b]
Fitness	41%	35%
Period/menstruation	21%[a]	35%[b]
Meditation/mindfulness	14%[a]	30%[b]
Stress reduction	11%[a]	28%[b]
Mood tracker	8%[a]	23%[b]
Nutrition	23%	21%
Depression	7%[a]	16%[b]
Medication reminder	5%[a]	13%[b]
Birth control	5%[a]	12%[b]
COVID-19 tracker	12%	7%
Quitting smoking/vaping	2%	5%
Drug or alcohol abuse	3%	3%
Any other health issue	1%	1%
Any mental health issue*	**28%[a]**	**48%[b]**
Any health issue	**68%**	**75%**

TABLE 27. Health-related mobile app use, by topic, among LGBTQ+ youth, 2018 to 2020

Among 14- to 22-year-old LGBTQ+ youth, percent who have ever used a mobile app related to ...	2018 (n = 157)	2020 (n = 248)
Sleep	22%[a]	39%[b]
Fitness	39%	35%
Period/menstruation	35%	35%
Meditation/mindfulness	20%[a]	30%[b]
Stress reduction	15%[a]	28%[b]
Mood tracker	11%[a]	23%[b]
Nutrition	28%	21%
Depression	10%	16%
Medication reminder	6%[a]	13%[b]
Birth control	7%[a]	12%[b]
COVID-19 tracker	NA	7%
Quitting smoking/vaping	3%	5%
Drug or alcohol abuse	4%	3%
Any other health issue	1%	1%
Any mental health issue*	**27%[a]**	**48%[b]**
Any health issue	**66%**	**75%**

TABLE 28. Connecting to health providers online, by LGBTQ+ identity, 2020

Percent of 14- to 22-year-olds who have connected to online health providers using ...	Non-LGBTQ+ (n = 1,179)	LGBTQ+ (n = 248)
Text messaging	13%[a]	23%[b]
Online messaging	12%[a]	19%[b]
Video appointment	26%	34%
An app	12%	12%
Other	3%[a]	7%[b]
Any of the above	**45%[a]**	**58%[b]**

TABLE 29. Satisfaction with connecting to health providers online, by LGBTQ+ identity, 2020

Among 14- to 22- year-olds who have connected to online health providers, percent who say it's been ...	Non-LGBTQ+ (n = 502)	LGBTQ+ (n = 141)
Very helpful	41%[a]	27%[b]
Somewhat helpful	49%	51%
Not too helpful	9%	15%
Not at all helpful	2%[a]	7%[b]

TABLE 30. Interest in connecting to health providers online in the future for the first time, by LGBTQ+ identity, 2020

Among 14- to 22-year-olds who have not connected to online health providers, percent who say they are ... in doing so	Non-LGBTQ+ (n = 677)	LGBTQ+ (n = 107)
Very interested	8%	12%
Somewhat interested	37%	43%
Not too interested	32%	26%
Not at all interested	23%	19%

TABLES 26 AND 27:
*Any mental health topic includes depression, meditation/mindfulness, mood tracker, stress reduction, and alcohol or drug abuse.

TABLES 26-30:
Note: Items with different superscripts differ significantly across rows ($p < .05$).

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We asked respondents to tell us about times that they had gone online to seek information about emotional well-being or to look for people who share the same health concerns.

Here is a sample of answers from LGBTQ+ young people:

"I follow accounts on social media of people who have similar health concerns to be surrounded by support and ideas [for] how to cope."

—14-year-old girl

"I once went to an online chat room thing for teens with anxiety, but I got nervous and left."

—14-year-old nonbinary person

"I was depressed and always angry and wanted to hurt and make other people feel the same feelings I did, so they actually knew how it felt. They said they knew how it was to be sad, but I don't think they know." (In a later response they shared that they had been able to connect online with a therapist and it helped with their "depression, stress, and anger.")

—14-year-old person who self-describes their gender as "I am whatever I want to be"

"I was going through tough times, and I wanted to find ways to help."

—15-year-old boy

"I am transgender and felt back pain due to chest binding. I was able to find tips to reduce my pain from other trans people through online forums."

—16-year-old boy

"There are some moments where I may feel feelings of despair, or loneliness, or jealousy. So I read articles written [by] other individuals who feel these same emotions and how to best cope [with] them."

—22-year-old woman

Social media and LGBTQ+ youth. LGBTQ+ teens and young adults are avid users of social media; indeed, 37% say they use social media "almost constantly," compared to 23% of non-LGBTQ+ youth (see Table 31). And, as with young people in general, this is a substantial increase over just two years (in 2018, 24% of LGBTQ+ youth said they were "almost constant" users of social media).

Homophobic content in social media. Nearly half (44%) of all LGBTQ+ youth say they "often" encounter homophobic comments on social media, with another 30% saying they do so "sometimes" (see Table 32).

Importance of social media. LGBTQ+ youth are also more likely than their non-LGBTQ+ peers to consider social media "very important" to them for creative expression, inspiration, feeling less alone, and getting support and advice when needed (28% say social media is very important for support and advice, compared to 19% of non-LGBTQ+ youth, see Table 33). As is the case with young people suffering from depression, LGBTQ+ youth are more likely in this survey wave to say social media is "very" important for support and advice than they were just two years ago (28% in 2020 vs. 12% in 2018).

Social media and depression. Given the importance of social media to so many young people who are part of a sexual or gender minority, whether for inspiration or connection or support, it is not surprising that LGBTQ+ youth are even more likely than non-LGBTQ+ youth to say that using social media helps them feel better when they are depressed, stressed, or anxious. More than half (52%) of LGBTQ+ youth say that using social media makes them feel better in such circumstances, compared to just 13% who say it makes them feel worse (see Table 34). This is an increase of 17 percentage points from just two years ago, in 2018, when 35% of LGBTQ+ youth said using social media made them feel better. For many LGBTQ+ youth, having a platform to connect with others, share feelings, get advice, and find inspiration is perceived as a positive force in their lives.

TABLE 31. Frequency of social media use, by LGBTQ+ identity, 2020

Percent of 14- to 22-year-olds who say they use social media ...	Non-LGBTQ+ (n = 1,179)	LGBTQ+ (n = 248)
Daily	81%	81%
• Almost constantly	23%^{a}	37%^{b}
• Multiple times a day	51%^{a}	39%^{b}
• Once a day	7%	6%
A few times a week	9%	9%
Weekly	2%	3%
Less than weekly	3%	3%
Never	5%	4%
Use social media	**95%**	**96%**

TABLE 32. Exposure to hate speech on social media, by LGBTQ+ identity, 2020

Among 14- to 22-year-old social media users, percent who encounter homophobic comments ...	Non-LGBTQ+ (n = 1,119)	LGBTQ+ (n = 239)
Often	18%^{a}	44%^{b}
Sometimes	39%^{a}	30%^{b}
Hardly ever	25%^{a}	17%^{b}
Never	18%^{a}	8%^{b}

TABLE 33. Importance of social media, by LGBTQ+ identity, 2020

Percent of 14- to 22-year-old social media users who say social media is "very" important to them for ...	Non-LGBTQ+ (n = 1,119)	LGBTQ+ (n = 239)
Expressing oneself creatively	23%^{a}	36%^{b}
Getting inspiration from others	21%^{a}	31%^{b}
Getting support/advice when needed	19%^{a}	28%^{b}
Feeling less alone	20%^{a}	28%^{b}

TABLE 34. Effect of social media when feeling depressed, stressed, or anxious, by LGBTQ+ identity, 2020

Among 14- to 22-year-old social media users, percent who say using social media when they are feeling depressed, stressed, or anxious makes them feel ...	Non-LGBTQ+ (n = 1,119)	LGBTQ+ (n = 239)
Better	42%^{a}	52%^{b}
Worse	17%	13%
Neither	42%	34%

TABLES 31-34:
Items with different superscripts differ significantly across rows ($p < .05$).

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Here is a sample of stories shared by LGBTQ+ youth about how they are using social media:

"I was curious about what celebrities have gone through/currently go through similar situations regarding their mental health. It was a sort of way to boost my confidence a bit, assuring myself that even great people like them go through similar things."

—14-year-old girl

"I guess just seeing people expressing themselves the way they want makes me happy because I can't really do that."

—14-year-old nonbinary person

"It helps me keep in contact with my high-risk friend who is always there for me, and it means the world that he's there for me to talk to."

—15-year-old girl

"Social media has made me feel less depressed because I can connect with people. When I feel alone because of the pandemic, I can go onto Instagram or Snapchat and talk with friends and see what they are doing. Then I see that we are all in this together and everyone is having a hard time, not just me."

—15-year-old boy

"By connecting with other people, social media has helped me feel less isolated, and therefore less depressed."

—22-year-old woman

CONCLUSION

THE CONFLUENCE OF EVENTS that occurred over the past year has vividly highlighted the contradictions inherent in the internet. These events include a very contagious deadly virus, a powerful movement for racial justice, a highly contested and bitter election, economic turmoil, closed schools, limited or prohibited social interactions, and orders to stay at home. In each case, the internet played a dual role—spreading terrifying news *and* sharing life-saving health guidance; sowing misinformation and hate *and* empowering people to participate in the political process from their dining room tables; bringing the horrors of police shootings onto devices in the palms of our hands *and* providing the tools to help build the movement for racial justice; connecting us to family and friends while reminding us of everything we're missing.

This survey explored the role of technology in the lives of adolescents and young adults during this tumultuous period. Adolescence is a critical developmental stage, and this past year disrupted it as never before, even as concerns about young people's mental health were already on the rise. Young adulthood is always a time of significant transitions, but during the pandemic those transitions were made exponentially more difficult. And for both age groups, technology was smack in the middle of it all.

How young people move forward from multiple societal and personal crises may depend on the extent to which their mental health needs can be met effectively in online spaces. In the 12 months since shelter-in-place orders were first imposed in the United States, millions of young people have turned to the internet for health information on COVID-19, but also on depression, anxiety, stress, and sleep. They used technology to connect to doctors, nurses, and therapists. They downloaded apps to meditate and track their moods. They searched out and found other young people who had struggled with and perhaps even overcome health challenges similar to their own.

For those most directly affected by COVID-19, the internet was an even more important lifeline. Depression has increased among young people across the country, but for those who have had family members actually get sick or die, depression is—not surprisingly—even higher. And for them, social media, online health information, and mobile apps have been a safety net in a time of need.

Because we conducted a baseline survey just two years ago (Rideout & Fox, 2018), it is possible to see how quickly certain things have changed in young people's lives. There have been substantial increases in both depression and social media use among teens and young adults—and the increase in social media use is most pronounced among those with depression. It is not the purpose of this research to attempt to identify a causal relationship between social media use and depression, in either direction. Rather, our purpose is to give voice to the millions of teens and young adults whose mental well-being is at stake in these challenging times, to explore the *how* and *why* of their social media use when they are depressed, and to add texture and depth and color to our understanding of their online lives.

Some experts argue that young people's use of social media is adding to their depression; others that their depression leaves them so uninterested in other activities that they turn to social media by default. This research suggests a third possibility: that many young people who are experiencing depression— whatever the cause—are purposely and proactively using social media and other digital tools to protect and promote their own well-being.

Young people themselves are far more likely to say that social media plays a positive rather than a negative role in their emotional lives, and since 2018 the scale has tipped even more toward the positive side of the ledger. Is this due to better content and more effective interventions online? A growing sophistication among young people at how to curate their online lives? Or are young people misinterpreting the effect of social media on their emotional health, mistakenly believing that it has a positive effect? Or could it be that different young people, with different levels of depression and different circumstances in their lives, respond to social media differently?

We hope this research helps bring to life the impressive degree to which young people are using social platforms to express their creativity, seek inspiration from others, maintain some semblance of a social life, boost their moods with humorous or inspirational content, and connect with others who are experiencing similar challenges. At the same time, there are indications that for young people suffering from the most severe level of depression, social media can be more challenging to navigate.

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This dovetails with existing research that shifts the focus from young people as a monolithic group to individuals who have unique risks online and varying degrees of vulnerability (Odgers & Robb, 2020). The number of individuals in this survey who reported severe depression was small, so more research on this group is needed. A cookie-cutter approach to tackling the relationship between social media and depression is not likely to work; one size does not fit all.

It is encouraging news for telehealth advocates—including psychiatrists and therapists working to promote mental health—that nearly half of young people have connected with providers online. Most of those who have done so are quite satisfied with the experience, a fact that augurs well for the use of telehealth services in the future. Young people with depression, and those at risk for substance use problems, are especially interested in pursuing online connections with providers. It may have taken a pandemic to jump-start the use of telehealth services, but now that it has done so, it seems likely it could lead to permanent changes in the delivery of care. This development has the potential to benefit young people by making appointments with therapists and other providers more convenient, and by increasing access to the types of culturally competent care that may not be available in their own communities.

Given the rise in exposure to hate speech online, one clear recommendation is for social media companies to take a much more active role in blocking hate speech and misinformation online. As hate speech is generally aimed at populations who are already vulnerable, and is likely exacerbating negative mental health outcomes, it is the responsibility of tech companies to do much more to protect young people during sensitive developmental points in their lives, even as they tackle questions of free speech and expression.

And lastly, the findings here clearly suggest we need much more investment in the digital mental health space, with mental health professionals, industry leaders, and young people themselves working together to design and develop better evidence-based tools and therapies. Especially at a time when traditional supports are unavailable, having high-quality digital services can clearly be an important part of young people's mental health portfolios, particularly given how many welcome them.

Issues to track as we go forward into 2021:

- Will this age group's rates of depression continue to rise, or can we find a way to stem the tide?
- Will the digital mental health safety net adapt to serve the wave of teens and young adults who report symptoms of moderate to severe depression, particularly those who have been directly affected by COVID-19?
- Will policymakers, clinicians, and health care payers work together to ensure that telehealth services, so popular among this age group, become a permanent feature of care delivery?
- Will social media companies and technology developers find new ways to empower young people to express themselves, find connection, and access useful information?
- Will providers, advocates, and tech companies develop ways to help young people choose among thousands of health apps of varying quality?
- Will expressions of online hate continue to grow, or will we as a society find ways to transform the public conversation?

Several limitations of our study are worth noting: First, as the study is cross-sectional, we do not attempt to make any claims about causality. Rather, we can look at the numbers in tandem with young people's own words to generate ideas about how tech use is affecting mental health, and vice versa. Second, poverty status has been identified elsewhere as a major factor in mental health (Odgers & Robb, 2020), so it is possible that knowing more about respondents' socioeconomic status would help us better understand depression status, and any policy recommendations for addressing mental health would likely have to tackle young people's economic conditions as well. And lastly, the questions in our depression scale, the PHQ-8, could potentially assess physical symptoms caused by COVID-19 (depending on when a respondent who had COVID-19 took the survey), and that may complicate the relationship between depression and COVID-19 status.

In closing, it is hard not to be struck by how many young people are coping with depression, and how quickly rates of depression have increased. Among certain groups of young people—those in the LGBTQ+ community and those most directly affected by COVID-19—rates of depression are heartbreakingly high. Yet it is very moving to see the degree to which young people are proactively participating in their own well-being, using digital tools to look for information, connect with providers, and seek inspiration. If we aren't meeting them in online spaces with high-quality, relevant digital tools, we are failing them at a time when they need support the most.

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METHODOLOGY

THIS REPORT PRESENTS THE results of a survey of 1,513 teens and young adults, age 14 to 22, conducted in September, October, and November 2020. Interviews were offered in English or Spanish, and were conducted either online or by telephone, depending on respondent preference. A total of 46 respondents took the survey in Spanish, and none chose to complete the survey by phone.

The survey was designed by Victoria Rideout of VJR Consulting and Susannah Fox of Internet Geologist LLC, with support from Michael Robb of Common Sense, and with funding from California Health Care Foundation, Common Sense Media, and Hopelab. A first wave of the survey was conducted in 2018; the original questionnaire was designed by Rideout and Fox in collaboration with Jana Haritatos and Emma Bruehlman-Senecal of Hopelab, with funding from Hopelab and Well Being Trust. Comparative data from that wave of the survey are included in this report. Both waves of the survey were fielded by the National Opinion Research Center (NORC) at the University of Chicago. Data analyses were conducted by Alanna Peebles of Common Sense. A copy of the complete questionnaire is included in the Appendix.

Sample. The 2020 sample includes U.S. residents age 14 to 22. Parental permission was obtained for all 14- to 17-year-old participants. Oversamples of Black and Hispanic/Latinx respondents were conducted sufficient to generate a total unweighted sample of 275 Black and 460 Hispanic/Latinx respondents. For analyses among the general population, Black and Hispanic/Latinx respondents were weighted down to their representative proportion, according to the most recent Census. Participants were offered the cash equivalent of $10 for completing the survey.

The majority of participants were recruited from NORC's AmeriSpeak® Panel (n = 865). AmeriSpeak® is a probability-based panel designed to be representative of the U.S. household population. Randomly selected U.S. households are sampled using area probability and address-based sampling, with a known, nonzero probability of selection from the NORC National Sample Frame. These sampled households are then contacted by mail, telephone, and in-person field interviewers (face-to-face). The panel provides sample coverage of approximately 97% of the U.S. household population. While most AmeriSpeak households participate in surveys by web, noninternet households can participate in AmeriSpeak surveys by telephone.

All eligible panelists were selected for invitation to this study. In addition, NORC reached out to all active panelists who were identified as parents of a teen age 14 to 17 (regardless if the child was part of the AmeriSpeak Panel) or living with a nonempaneled 18- to 22-year-old adult. The parent panelists were provided with general information about the study and given the opportunity to provide consent for AmeriSpeak to contact their teen(s), both empaneled teens and any potential teens not currently empaneled.

The AmeriSpeak panel sample was supplemented with respondents from Dynata's nonprobability online opt-in panel (n = 648). Dynata provided access to 18- to 22-year-old respondents by sending the Dynata respondent directly into the AmeriSpeak survey. Dynata prescreened parents on their panel for permission to survey their 14- to 17-year-old children, who then connected to the survey hosted by AmeriSpeak. To reduce potential bias in the nonprobability sample, Dynata attempted to balance the nonprobability respondent sample by age, race and ethnicity, geography, and education.

Weighting. NORC calculated panel weights for the completed AmeriSpeak Panel and nonprobability online interviews. In order to incorporate the nonprobability sample, NORC used TrueNorth calibration services, an innovative hybrid calibration approach developed at NORC, based on small area estimation method and designed to explicitly account for potential bias associated with the nonprobability sample. The purpose of TrueNorth calibration is to adjust the weights for the nonprobability sample, so as to bring weighted distributions of the nonprobability sample in line with the population distribution for characteristics correlated with the survey variables. Such calibration adjustments help to reduce potential bias, yielding more accurate population estimates.

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Data cleaning. NORC applied cleaning rules to the survey data for quality control by removing respondents who provided responses indicative of speeding through the survey, skipping survey questions, and/or answering open-ended questions with gibberish. Respondents were considered speeders if they completed the interview in less than one-third the median duration. Respondents were considered skippers if they skipped more than 50% of questions asked.

Margin of error and response rates. The study design effect is 1.81, and the margin of sampling error for the survey is +/- 3.64%. The margin of sampling error may be higher for subgroups.

The American Association for Public Opinion Research (AAPOR) defines several component rates used to calculate final response rates. It is not possible to calculate response rates for nonprobability samples. Using the AAPOR definitions, the response rates for the AmeriSpeak portion of the sample are:

- Weighted AAPOR RR3 recruitment rate: 20.4%
- Weighted household retention rate: 80.7%
- Screener completion rate: 43.6%
- Eligibility rate: 84.7%
- Survey completion rate: 38.2%
- Weighted AAPOR RR3 cumulative response rate: 2.7%

Statistical significance. Where relevant, differences among subgroups and/or over time have been tested for statistical significance. Unless otherwise noted, these findings are only described in the text in a comparative manner (e.g., "more than," "less than") if the differences are statistically significant at the level of $p < .05$. In tables where statistical significance has been tested, superscripts (using letters such as a, b, or c) are used to indicate whether results differ at a statistically significant level ($p < .05$) within a set of columns or rows (e.g., by age groups or by year). Means that share a common superscript and means that have no superscript at all are not significantly different from each other.

For example, in Row 1 below, none of the items differ in a statistically reliable way. In Row 2, each item differs from the other significantly. In Row 3, the items in the first and third columns differ from the item in the second column, but not from each other. And in Row 4, items in Columns 1 and 3 differ from each other, but not from Column 2.

Examples of statistical significance:

	Column 1	Column 2	Column3
Row 1	70%	75%	65%
Row 2	20%[a]	35%[b]	50%[c]
Row 3	43%[a]	60%[b]	37%[a]
Row 4	13%[a]	17%[ab]	23%[b]

Analyses. Data presented in this report include descriptive findings for the sample population as a whole and the results of bivariate analyses by demographics (age, gender, race/ethnicity, and sexual orientation) and by other variables of interest (level of depressive symptoms and likely risk for problematic substance use). Because the economic and educational circumstances of respondents in the different age groups included in this survey are not directly comparable to one another (for example, living with parents while attending high school, or working a first job out of college), data were not analyzed by household income or level of education.

Comparisons over time. Many items in the survey repeat questions that were administered to a separate cross-sectional sample in 2018 titled *Digital Health Practices, Social Media Use, and Mental Well-Being Among Teens and Young Adults in the U.S.* (Rideout & Fox, 2018). Where possible, results are compared to explore changes over time. Where question wording was changed sufficient to render comparisons unreliable, a note has been included. In addition, one series of questions in the current survey repeats an item from a 2018 Common Sense survey *Social Media, Social Life: Teens Reveal Their Experiences* (Rideout & Robb, 2018). This trend data is also presented in this report.

Changes over time have been tested for statistical significance. In the surveys conducted in 2018, the sample was not supplemented with nonprobability participants, as this year's survey was. The use of TrueNorth calibration in 2020 was designed to reduce any possible bias from the inclusion of opt-in respondents (see Weighting, above). Nonetheless, changes over time should still be interpreted with caution.

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Open-ended responses. The survey included several open-ended questions in which we invited respondents to describe, in their own words, their experiences and how they felt about them. In total, more than 2,500 substantive open-ended responses were received, including:

- More than 650 participants who shared experiences looking for information about depression, stress, or anxiety online.
- 125 who shared about looking for information on drug and alcohol abuse online.
- More than 500 who described their efforts to connect with health peers online.
- More than 550 who shared their experiences connecting with health providers online.
- 489 who discussed how using social media has made them feel either "more" or "less" depressed during the coronavirus pandemic.

These open-ended questions yielded a substantial amount of qualitative data and many valuable insights.

The responses were read and hand-coded to look for patterns and themes. All statistical findings presented in the report are from the quantitative items, but insights gained from the review of open-ended responses are included in the text. Throughout the report, a selection of verbatim quotes from those open-ended questions is included. These quotes have been lightly edited to correct misspellings, punctuation, capitalization, and typos. In the sections of the report devoted to specific topics (e.g., LGBTQ+ youth, young people with severe levels of depression), quotes were selected from young people with those attributes.

Subgroups. Findings are analyzed by various subgroups throughout the report. Unweighted *n* values are provided for each group in the tables. Definitions of groups are provided below. We were not able to include a consistent and accurate measure of household income because of the disparate circumstances in this age group (e.g., living with their parents, at college, working and supporting families of their own).

Age. The survey was conducted among 14- to 22-year-olds. Throughout the report, we refer to this population as "teens and young adults." We occasionally use the terms "youth" or "young people" as shorthand to refer to this 14- to 22-year-old age group. We also discuss two developmentally distinct subpopulations as part of this broader group: "teens" (14 to 17 years old) and "young adults" (18 to 22 years old).

COVID-19 impact. The survey included an item asking respondents whether they or anyone in their family had become ill or died from the coronavirus. Fourteen percent indicated they had. These respondents are classified as "COVID-19 in family" and those who replied "no" to that question are referred to as "no COVID-19 in family." Respondents who skipped this question were excluded from these analyses ($n = 33$).

Depressive symptoms. The survey employed a previously validated scale for assessing depressive symptoms: The Patient Health Questionnaire Depression Scale (PHQ-8). The PHQ-9 (with an additional question about suicide that was omitted from this survey) has been validated for use among adolescents, and the PHQ-8 has been validated among the general population as a measure of current depression (Allgaier et al., 2012; Kroenke et al., 2009; Richardson et al., 2010). In accordance with the scale protocol, responses were coded numerically and summed, so that each respondent was given a total score between 0 and 24 points. Respondents who were missing data on scale items were excluded from these analyses.

The scale identifies cut points of levels of depressive symptoms: none (0 to 4), mild (5 to 9), moderate (10 to 14), moderately severe (15 to 19), and severe (20 to 24). The scale protocol indicates that a score of 10 or greater is considered a "yellow flag," drawing attention to a possible clinically significant condition warranting further attention.[1] Therefore, for purposes of data analysis, in this report respondents were classified into three groups by level of depressive symptoms: none (0 to 4), mild (5 to 9), and moderate to severe (10 or higher).

Throughout the report, we occasionally refer to respondents who score 10 or higher on the scale as "depressed" or as individuals "with depression." However, it should be recognized that there is an important difference between a score of 10+ on the PHQ-8 and a clinical diagnosis of depression, which is a diagnostic assessment made by a trained, licensed medical or mental health practitioner.

This survey is not intended as a comprehensive assessment or analysis of the extent and severity of depressive symptoms among teens and young adults. The primary purpose of including such measures is to explore how those young people who report

1. Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures: https://www.ons.org/sites/default/files/PHQandGAD7_InstructionManual.pdf

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current depressive symptoms describe a wide range of digital health and social media behaviors and experiences, and whether their experiences are different than among those without current depressive symptoms. The findings presented are descriptive and cross-sectional only; they cannot be interpreted as implying causality. Indeed, the purpose of this particular survey is not to assess what is causing depression, but rather to give voice to young people's experiences, and provide data that can help those working with or providing services to teens and young adults to better meet their needs.

LGBTQ+. The LGBTQ+ category includes respondents who identify their sexual orientation as lesbian, gay, bisexual, or "something else," or who consider themselves to be transgender or nonbinary, or who prefer to self-describe their gender. Participants were excluded from analyses related to LGBTQ+ identity if they answered "I don't know" or skipped any of the survey questions on sexual orientation, transgender identity, or gender identity.

Race/ethnicity. The survey used the standard U.S. Census measures for identifying respondents' race and ethnicity. In the report, the term Hispanic/Latinx is used to refer to anyone who self-identified as "Hispanic." The term "White" refers to any respondents who identified as "white, non-Hispanic." The term "Black" refers to respondents who self-identified as "black, non-Hispanic." Where findings are broken out by race/ethnicity, results are presented only for White, Black, and Hispanic/Latinx respondents. Respondents in other categories, such as Asian, Pacific Islander, or Native American, are included in all findings based on the total sample, but not in the results that are broken out by race/ethnicity, due to smaller sample sizes.

Problematic substance use. The survey included the CRAFFT screener to identify young people at risk for problematic substance use. CRAFFT is a screening tool designed to identify those age 12 to 21 at risk for problematic substance use, so that they can receive counseling or other interventions. The screener consists of six items; each "yes" response equals one point, and therefore scores range from 0 to 6. The CRAFFT manual states that a person is considered "high risk" if they have a total score of 2 or more (Center for Adolescent Behavioral Health Research, 2020). However, other research has identified higher cut points as optimal in identifying those most at risk, especially among older teens and young adults. Specifically, this research suggests a cut point of 3 or higher for 12- to 17-year-olds (Harris et al., 2016; Mitchell et al., 2014) and 4 or higher for 18- to 25- year-olds (Kelly et al., 2009). Therefore in this report, we used these higher, age-adjusted scores in all analyses comparing those at risk for problematic substance use to those not at risk. Nine respondents did not complete the CRAFFT screener and are excluded from these analyses.

This survey is not intended as a comprehensive assessment or analysis of the extent and severity of substance use problems among teens and young adults. Rather, the purpose of conducting these analyses is to better understand the online health behaviors of young people most at risk for problematic substance use. The findings presented are descriptive and cross-sectional only; they cannot be interpreted as implying causality.

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APPENDIX: QUESTIONNAIRE

Q1. Have you ever gone online, whether through a website, a search engine, an app, or any other means, to look for information on any of the following health topics? *Please select all that apply.*

[RANDOMIZE]

a. Depression
b. Drug or alcohol abuse
c. Diet and nutrition
d. Fitness and exercise
e. Eating disorders (such as anorexia or bulimia)
f. Pregnancy
g. Birth control
h. STDs (sexually transmitted diseases, such as herpes or HIV/AIDS)
i. Stress
j. Anxiety
k. Sleep disorders
l. Smoking or vaping
m. Cancer
n. Diabetes
o. Heart disease
p. COVID-19 (the coronavirus)
q. Any other mental health issue [SPECIFY]
r. Any other physical health issue [SPECIFY]
s. None of the above

[IF Q1=a, i, or j]

Q2A. Please give us an example of a time you went online to get health information about depression, stress, or anxiety. What was the situation? Did you find what you were looking for? Did it help? If so, how? [OPEN END]

[IF Q1=b]

Q2B. Please give us an example of a time you went online to get information about drug or alcohol abuse. What was the situation? Did you find what you were looking for? Did it help? If so, how? [OPEN END]

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Q3. Have you ever gone online to find other people who might have health concerns similar to yours?

Yes

No

[IF Q3=Yes]

Q4. Please give us an example of a time you went online to try to find other people with health concerns similar to yours. What was the situation? How did it turn out? [OPEN END]

Q5. Have you ever used a mobile app related to any of the following? *Please select all that apply.* [RANDOMIZE]

a. Fitness
b. Period/menstruation
c. Nutrition
d. Depression
e. Meditation/mindfulness
f. Mood tracker
g. Sleep
h. Stress reduction
i. Medication reminder
j. Quitting smoking or vaping
k. Alcohol or drug abuse
l. Birth control
m. COVID-19 (such as a symptom tracker)
n. Any other health-related topic
o. None of the above

Q6. Have you ever connected to a health provider (such as a doctor, nurse, therapist, or counselor) through: *Please select all that apply.* [RANDOMIZE]

a. Text messaging
b. Online messaging
c. Video appointment
d. An app
e. Other [SPECIFY]
f. None of the above

[SHOW IF Q6=a,b,c,d,e]

Q7. You mentioned that you have connected with a doctor, nurse, therapist, or counselor online. In general, how helpful has it been for you to connect with a health provider online?

a. Very helpful
b. Somewhat helpful
c. Not too helpful
d. Not at all helpful

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[SHOW IF Q6=a,b,c,d,e and Q7=a,b,c,d]

Q8. Please give us an example of how connecting with a health provider or therapist online *[IF Q7=a,b: was, IF Q7=c,d: was not]* **helpful.** *[IF Q7=a,b: What worked well?]* **What could be improved?** [OPEN END]

[SHOW IF Q6=f]

Q9. How interested are you, if at all, in being able to connect with a health provider online, such as video appointments, or text messaging them?

a. Very interested
b. Somewhat interested
c. Not too interested
d. Not at all interested

[SHOW IF Q9=c,d]

Q10. Why aren't you interested in being able to connect with a health provider online? ***Please select all that apply.*** [RANDOMIZE]

a. I don't have any health issues I need to see a provider about
b. I'd rather meet or talk to health providers in person
c. I'm worried about being overheard
d. I'm worried about the security or confidentiality of my health information online
e. I'm worried about my family finding out
f. I'm worried about how much it costs
g. Other [SPECIFY]

The next questions concern social media, such as Instagram, Snapchat, Twitter, or Facebook.

Q11. How often are you on social media?

a. Almost constantly
b. Several times a day
c. Once a day
d. A few times a week
e. Once a week
f. Less than once a week
g. Never – I don't use social media

[SHOW IF Q11=a,b,c,d,e,f]

Q12. How important is social media to you for: [RANDOMIZE]

a. Getting support or advice when you need it
b. Expressing yourself creatively
c. Getting inspiration from others
d. Feeling less alone
   1. Very important
   2. Somewhat important
   3. Not too important
   4. Not at all important

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[SHOW IF Q11=a,b,c,d,e,f]

Q13. Which of the following statements comes closest to the truth for you? When I'm feeling depressed, stressed, or anxious, using social media usually:

a. Makes me feel better

b. Makes me feel worse

c. Neither

[SHOW IF Q11=a,b,c,d,e,f]

Q14. Do you agree or disagree with the following statements? [RANDOMIZE]

a. I see so much bad news in social media that it makes me stressed and anxious

b. I prefer to communicate with people through social media rather than in person

1. Strongly agree
2. Somewhat agree
3. Somewhat disagree
4. Strongly disagree

[SHOW IF Q11=a,b,c,d,e,f]

Q15. How often, if ever, have you encountered the following types of comments in social media? [RANDOMIZE]

a. Racist comments, that is, someone putting people down based on their race or ethnicity such as for being Black, Hispanic, Asian, or White, or using insulting words that refer to race

b. Homophobic comments, that is, someone putting people down for being gay, or using insulting words about being gay

c. Sexist comments, that is, someone putting people down in a way that calls attention to their gender, or using insulting words about women or men

d. Body shaming comments, that is, someone putting people down for being overweight, underweight, or unattractive

1. Often
2. Sometimes
3. Hardly ever
4. Never

[SHOW IF Q11=a,b,c,d,e,f]

Q16. How important has using social media during the coronavirus pandemic been in:

a. Keeping you informed about current events

b. Helping you learn how to protect yourself and others from the virus

c. Staying connected to friends and family

1. Very important
2. Somewhat important
3. Not too important
4. Not at all important

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[SHOW IF Q11=a,b,c,d,e,f]

Please choose the answer that best applies to your experience using your main social media site, that is, the one you use most often.

Q17A. During the coronavirus pandemic, using my main social media site has made me feel:

1. More anxious
2. Less anxious
3. Hasn't made much difference one way or the other

Q17B. During the coronavirus pandemic, using my main social media site has made me feel:

1. More lonely
2. Less lonely
3. Hasn't made much difference one way or the other

Q17C. During the coronavirus pandemic, using my main social media site has made me feel:

1. More depressed
2. Less depressed
3. Hasn't made much difference one way or the other

[SHOW IF Q17C=1,2]

Q18. In what ways has social media made you feel *[IF Q17C=1: more, IF Q17C=2: less]* **depressed during the coronavirus pandemic? Please give us an example of how you use social media at those times.** [OPEN END]

Q19. Which of the following, if any, have happened to you since the start of the coronavirus pandemic:
Please select all that apply. [RANDOMIZE]

a. You or a family member have lost a job or income due to the coronavirus
b. You have had to take on more family responsibilities due to coronavirus, such as getting a job or taking care of children
c. Your in-person school was cancelled due to the coronavirus
d. Your household has become more crowded due to the coronavirus
e. You have been separated from your family due to the coronavirus
f. You or someone in your family became ill from the coronavirus
g. You haven't been able to get needed physical or mental health care due to the coronavirus
h. You have gotten more sleep
i. You have felt emotionally closer to your family members
j. You have felt less anxious with no school and other activities
k. You have gotten more exercise

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This is the final section of the survey. These last few questions help us understand more about how people feel.
Remember, all your answers are confidential.

(PHQ-8 – Depression)

Q20. Over the last 2 weeks, how often have you been bothered by the following problems?

a. Little interest or pleasure in doing things

b. Feeling down, depressed, or hopeless

c. Trouble falling asleep, staying asleep, or sleeping too much

d. Feeling tired or having little energy

e. Poor appetite or overeating

f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

g. Trouble concentrating on things – such as reading the newspaper or watching television

h. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual

1. Not at all
2. Several days
3. Over half the days
4. Nearly every day

(GAD-7 Generalized Anxiety Disorder scale)

Q21. Over the last 2 weeks, how often have you been bothered by the following problems?

a. Feeling nervous, anxious, or on edge

b. Not being able to stop or control worrying

c. Worrying too much about different things

d. Trouble relaxing

e. Being so restless that it's hard to sit still

f. Becoming easily annoyed or irritable

g. Feeling afraid as if something awful might happen

1. Not at all
2. Several days
3. Over half the days
4. Nearly every day

Q22S. Do you ever use alcohol or drugs?

Yes

No

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(CRAFFT Substance Use Disorder screener)

[SHOW IF Q22S=Yes]

Q22. The following questions concern alcohol and drug use. *Please answer yes or no to each item.*

a. Have you ever ridden in a car driven by someone (including yourself) who was "high" or using alcohol or drugs?

b. Do you use alcohol or drugs to relax, change your mood, feel better about yourself, or fit in?

c. Do you ever use alcohol or drugs while you are by yourself, alone?

d. Has any friend, family member, or other person ever thought you had a problem with alcohol or drugs?

e. Do you ever forget (or regret) things you did while using?

f. Have you ever got into trouble while using alcohol or drugs, or done something you would not normally do (break the law, rules, or curfew; engage in risky behavior to you or others)?

Q23. Does anyone in your household, not including yourself, suffer from a mental health problem like depression or anxiety?

Yes

No

Q24. What sex were you assigned at birth, on your original birth certificate?

Male

Female

Q25. How do you describe your gender?

a. Male

b. Female

c. Nonbinary

d. Prefer to self-describe [SPECIFY]

e. Prefer not to say

Q25A. Do you identify as transgender?

Yes

No

Q26. This next question is about sexual orientation. Which of the following best represents how you think of yourself?

a. Lesbian or gay

b. Straight, that is, not lesbian or gay

c. Bisexual

d. Something else

e. Don't know

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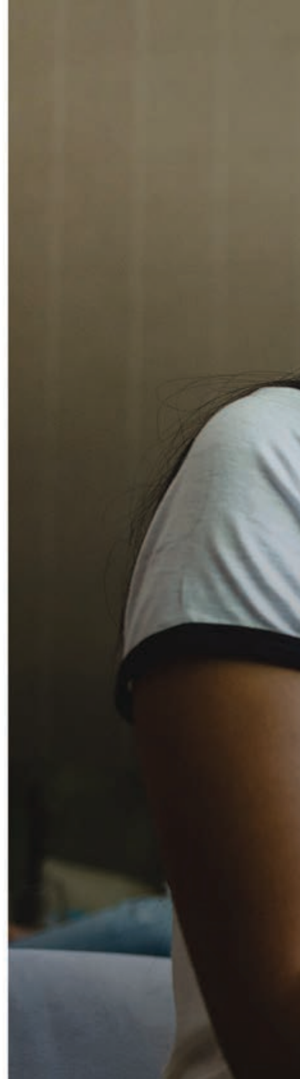

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[Questions submitted for the record and the responses by Mr. Morial follow:]

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April 7, 2021

Mr. Marc H. Morial, J.D.
President and CEO
National Urban League
80 Pine Street, 9th Floor
New York, NY 10005

Dear Mr. Morial,

I would like to thank you for testifying at the March 25, 2021 Subcommittee on Early Childhood, Elementary, and Secondary Education at the hearing entitled "*Lessons Learned: Charting the Path to Educational Equity Post-COVID-19.*"

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Wednesday, April 14, 2021, for inclusion in the official hearing record. Your responses should be sent to Lakeisha Steele of the Committee staff. She can be contacted at 202-225-3725 should you have any questions.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Early Childhood, Elementary, and Secondary Education Subcommittee Hearing
"Lessons Learned: Charting the Path to Educational Equity Post-COVID-19"
Thursday, March 25, 2021
1:00 p.m. (Eastern Time)

Representative Frederica S. Wilson (D – FL)

1. Mr. Marc Morial, a lot of emphasis has rightfully been placed on the $23 billion racial funding gap between districts serving predominantly students of color and districts with a majority of white students. However, I believe that in order to mitigate long-standing disparities in student achievement that have been deepened by the pandemic we must also address home resource disparities. What is the importance of ensuring that all students can access a space conducive to learning in their own home that includes a laptop, desk, and desk chair? How would this impact the racial achievement gap?

Representative Joseph D. Morelle (D – NY)

1. Mr. Marc Morial, throughout the pandemic, we've seen that access to affordable broadband is essential for ensuring basic functions like distance learning and telehealth can continue while Americans are staying safe. However, millions of children across the U.S. are caught up in the digital divide, and we know it is most pronounced in rural communities and households with Black, Latino, and Native American students.

   In December, Congress allocated funding to help subsidize broadband subscriptions for low-income households affected by the pandemic and the American Rescue Plan included billions of dollars to expand connectivity for schools and libraries to address the "homework gap," but additional strong investments in broadband will certainly be needed post-pandemic as well.

   While the federal government is providing money to help address the digital divide and some companies and corporations have also stepped up to assist families, how can communities sustain their efforts once COVID-relief funding ends and what permanent investments can the federal government make to ensure all students have access to high-speed internet and devices?

Early Childhood, Elementary, and Secondary Education Subcommittee Hearing
"Lessons Learned: Charting the Path to Educational Equity Post-COVID-19"

Responses to Questions for the Record

Representative Frederica S. Wilson (D – FL)

1. Mr. Marc Morial, a lot of emphasis has rightfully been placed on the $23 billion racial funding gap between districts serving predominantly students of color and districts with a majority of white students. However, I believe that in order to mitigate long-standing disparities in student achievement that have been deepened by the pandemic we must also address home resource disparities. What is the importance of ensuring that all students can access a space conducive to learning in their own home that includes a laptop, desk, and desk chair? How would this impact the racial achievement gap?

Ensuring that students of color have access to opportunity absolutely includes their environment outside of the school building just as much as inside the school building. This has always been true, and has become increasingly apparent as the physical classroom has been replaced by a virtual one, at home. Access to high speed internet and computer devices has become paramount to student learning. Yet, our research shows that an estimated 17 million school-aged children or 1 in 3 Black, Latino and Native American students lack the internet connectivity or device needed to learn in a virtual environment in their homes. That is why the work of the National Urban League and the Urban League Affiliates has been so important. Many Urban Leagues have formed public-private partnerships with their cities and school districts to ensure every child has access to a device and internet connection to learn from home. Housing stability also impacts a child's ability to focus and learn. Urban League affiliates are also providers of housing counseling services to make sure families with children have a safe, affordable and decent home to live in and are not victims of eviction or foreclosure due to the pandemic.

Representative Joseph D. Morelle (D – NY)

1. Mr. Marc Morial, throughout the pandemic, we've seen that access to affordable broadband is essential for ensuring basic functions like distance learning and telehealth can continue while Americans are staying safe. However, millions of children across the U.S. are caught up in the digital divide, and we know it is most pronounced in rural communities and households with Black, Latino, and Native American students.

In December, Congress allocated funding to help subsidize broadband subscriptions for low-income households affected by the pandemic and the American Rescue Plan included billions of dollars to expand connectivity for schools and libraries to address the

"homework gap," but additional strong investments in broadband will certainly be needed post-pandemic as well.

While the federal government is providing money to help address the digital divide and some companies and corporations have also stepped up to assist families, how can communities sustain their efforts once COVID-relief funding ends and what permanent investments can the federal government make to ensure all students have access to high-speed internet and devices?

We thank President Biden and the members of Congress who supported the *American Rescue Plan.* Among much-needed federal investment is the funding to address the digital divide. In addition to this investment, and to continue to close and keep closed the digital divide in the future, we need sustained corporate investments in public-private partnerships. Many companies have partnered with school districts to offer free internet services and devices to children in need. And they are partnering with Urban Leagues and other nonprofit organizations to educate the public on those new services. Public private partnerships play a crucial role in ensuring there is a sustained commitment for lasting change. In addition, the federal government can and should provide the social safety net to make sure no child or family gets left out of the digital revolution. In the same way that America's highway infrastructure incentivized private industry investments to develop cities and towns, broadband connectivity can be similarly expanded through federal government incentives (grants and credits) to ensure that all Americans can access reliable, high speed internet in their homes. Additionally, the federal government should extend the Emergency Broadband benefit and develop a long-term solution for ensuring all Americans, including the extreme poor, have access to an at-home broadband internet connection if they want it.

[Whereupon, at 3:49 p.m., the subcommittee was adjourned.]