



## **Written Testimony**

**Submitted to Illinois Senate Human Services and Public Health Committee**

**Submitted by Dr. Wendi Wills El-Amin, Associate Dean of Equity, Diversity and Inclusion  
SIU School of Medicine**

My name is Dr. Wendi Wills El-Amin. I am the Associate Dean of Equity, Diversity, and Inclusion at Southern Illinois University School of Medicine. I am a physician who practices family medicine. I speak to you, not just as a physician and an academic, but through the lens of an African-American woman. We commonly hear about social determinants of health, and I believe that racism is a determinant. I also believe that you have a critical role in determining the political determinants of health that can create lifesaving access and resources for the community.

“We wear the mask with torn and bleeding hearts we smile” this line from Paul Lawrence Dunbar’s 1895 poem eloquently captures the invisible mental impact of race based trauma. In 2020, black people we are still wearing mask, to manage everyday interactions, overt racism and micro-aggressions. As we all witnessed racial trauma this year, it seems that more people are beginning to see beyond the masks that people of color have worn to survive.

For those of us with darker shades of skin, sometimes peace in everyday activities is not our reality. Instead, we learn to remain in a heightened state of alert constantly aware that in any moment the value of our lives can be diminished. The threat and likelihood of physical and emotional harm disrupts freedom, peace, and our mental and physical health. For many, the act of grocery shopping, taking a walk in the park, jogging through a neighborhood, or driving through town are part of their natural day and these activities are done with a sense of peace.

In a free society, we want people to move through their days pursuing their best lives. However, for people of color these every day interactions can cause both psychological and physiological responses – a race based trauma response.

All of our bodies have a stress response. If you think of a high stress moment, you immediately know the body's signs of stress. When our nervous system kicks into action, stress hormones release and prepare us for an emergency action...heart pounding, muscles tense, and blood pressure rise. This physical response heightens our awareness and prepares us to fight, flee, or hide. We are all familiar with fight or flight response, but we do not hear about the ways that we freeze and submit or the ways that the response impacts our physical and mental health. For those of us surrounded by the constant, sometimes life or death, threat of racism, repeat activation of the stress response has a long-term health impact on the body.

Racial trauma has a cumulative negative effect on the lives of people of color. This trauma encompasses the emotional, physiological, health, economic, and social effects of

multigenerational and historical harms. We see the impact of racial based trauma in both the urban and rural communities in the state of Illinois. The damaging health effects stem from ongoing 1) internalized racism, 2) overt racist experiences, 3) the systemic discrimination and oppression within the lives of people of color.

Back in 2001, the US Surgeon General Dr. David Satcher stated that ethnic and racial health disparities were likely due to racism and discrimination. As we further research these disparities, our knowledge about racial trauma has risen as a potential significant contributor. Racial trauma refers to the mental and emotional injury caused by encounters with racial bias and ethnic discrimination, racism, and hate crimes.

Please think about your sphere of influence because your decisions drive mental health outcomes in our backyard. We know racial trauma is at critical mass when we look at recent indicators found in the Illinois Department of Public Health Disparities Report for Illinois and Illinois Counties.

- Black children had the highest rate of both accidental and homicide death rates.
- Higher rates reporting suffering from adverse childhood experience (ACE) was observed among women and Blacks. ACEs have been shown to have tremendous impact on lifelong overall health and well-being.
- Homicide, opioid overdose death, and all cancer rates were highest among Blacks
- Disparities in obesity prevalence and tobacco use during pregnancy increased among Blacks and Hispanics.
- Blacks in Illinois attained less education than all other race and ethnic groups and had the highest rate of high school dropout.

These mental health outcomes show up as an increased emotional and cognitive load that impacts esteem, drive depression, anxiety, and PTSD and exacerbate other mental health disorders we are seeing increased racial disparities show up during the COVID pandemic. We are also seeing people of color trying to navigate vicarious race based trauma absorbed by media outlets daily on top of experiencing the complexities of COVID. This connects to diminished participation in healthy behaviors and/or increased engagement in unhealthy behaviors.

You do not have the time for me to list all of the research that has been compiled about the mental and physical effects of racial trauma. I want to note the following

- In 1999, Clark and colleagues shared, “When a person of color perceives an environmental stimulus as racist, it results in a sequelae of psychological and Physiological Stress responses that can seriously compromise both mental and physical health and wellbeing.”

- There are also links between African Americans' racial trauma and hypertension, heart disease, and poor functioning of the immune system. (Brondolo, Rieppi, Kelly, & Guerin, 2003; Clark et al., 1999)

We must apply the same scientific rigor and public health response to solving this problem as we are to COVID-19. A recent SAMHSA report, " Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S." highlighted the effect of poverty, housing density, stress-related health conditions, employment conditions and lack of health care during the pandemic. One of the findings is that Black and Latinx communities have significantly lower access to mental health care, often terminate prematurely, and experience less culturally responsive care.

#### Potential Solutions

- Increase funding for training mental and behavioral culturally competent providers
- Data Disaggregation
- Flexibility in treatment policies and payments
- Expansion of telehealth
- Grants to support faith-based organizations and community based organizations
- Increase mental health workforce
- Develop technology to increase mental health outreach

While their rates of behavioral health disorders may not be significantly differ from the general population, Blacks and Latinos have substantially lower access to mental health and substance use treatment (NSDUH 2020).

- 88.7% of Blacks receive no treatment for substance abuse
- 69.7% of Blacks receive no treatment for mental illness
- 89.7% of Latinos receive no treatment for substance abuse
- 67.1% of Latinos receive no treatment for mental illness

There is lifesaving work to be done to close this disparity gap in access to care for mental health and substance abuse services. We each have a lifesaving role to play. We cannot be bystanders. Many recognize CPR as a lifesaving skill that can save others. Today, I am promoting a different type of CPR, one aimed to eradicate racial trauma.

- C – Critical conversations and action that recognizes that racism threatens health.
- P – Practice awareness and spot inequity and racism and take action.
- R – Respond with policies that systematically address racial trauma and improve health.



**Written Testimony**  
**Submitted to Illinois Senate Human Services and Public Health Committee**  
**Submitted by Dr. Kari Wolf, Chair of the Department of Psychiatry**  
**SIU School of Medicine**

As the only medical school in the state that was legislatively developed to address the health of central and southern Illinois, we have developed an array of services to cover a broad geographic footprint. We are the only medical school in the country that actually owns its own FQHC and have spread that FQHC to numerous sites around the state. We have an office of correctional medicine and actively provide psychiatric services to Pontiac and Logan Correctional Centers. We also provide numerous MAT clinics and behavioral health services around the state through our network of FQHC's.

According to the most recent data from the American Association of Medical Colleges, 4% of psychiatry residents nationally are black. At SIU, 19% of our psychiatry residents are black. While SIU Medicine has an above average rate of black psychiatrists, it is clear that it is time to turn our state and national attention to increasing the black mental health workforce and culturally competent behavioral health professions. This need only deepens the challenges of access to mental health services in Illinois.

- Mental Health America ranks Illinois 29<sup>th</sup> in the country in mental health workforce availability based on its 480-to-1 ratio of population to mental health professionals, and the Kaiser Family Foundation estimates that only 23.3% of Illinoisans' mental health needs can be met with its current workforce. Long wait times for appointments with psychiatrists—4 to 6 months in some cases— high turnover, and unfilled vacancies for social workers and other behavioral health professionals have eroded the gains in insurance coverage for mental illness and substance use disorder (SUD) under the Affordable Care Act (ACA) and parity laws. Illinois faces a statewide crisis in behavioral health access due to its inadequate workforce capacity.
- Fueled by the growing opioid epidemic, drug overdoses have now become the leading cause of death nationwide for people under the age of 50. According to the Illinois Department of Public Health, opioid overdoses have killed nearly 11,000 people in Illinois since 2008. Just last year, nearly 2,000 people died of overdoses—almost twice the number of fatal car accidents. Beyond these deaths are thousands of emergency department visits, hospital stays, as well as the pain suffered by individuals, families, and communities.
- Shortages are especially acute in rural areas and among low-income and under-insured individuals and families. 30.3% of Illinois' rural hospitals are in designated primary care shortage areas and 93.7% are in designated mental health shortage areas. Nationally, 40% of psychiatrists work in cash-only practices, limiting access for those who cannot afford high out-of-pocket costs. Community mental health centers have long argued that low

Medicaid reimbursement rates limit capacity and do not allow for expanding access to services or cover the costs of recruiting and retaining teams for evidence-based behavioral health practices like Assertive Community Treatment.

- The behavioral health community in Illinois has been raising the alarm on a workforce crisis for years. Estimates of unmet need consistently highlight the dire situation in Illinois. Over 4.8 million Illinoisans (38%) live in a designated mental health shortage area<sup>1</sup>; community behavioral health centers spend months to fill vacancies for psychologists and social workers; and waitlists for services at understaffed agencies stymie attempts to divert individuals from criminal justice involvement or prevent manageable behavioral health symptoms from becoming disabling conditions. Research from the University of Southern California’s Leonard Schaeffer Center for Health Policy and Economics showed a 23% decrease in the number of behavioral health care professionals per 10,000 Illinois residents between 2016 and 2018.
- Mental Health America ranks Illinois 29<sup>th</sup> in the country in mental health workforce availability based on its 480-to-1 ratio of population to mental health professionals,<sup>3</sup> and the Kaiser Family Foundation estimates that only 23.3% of Illinoisans’ mental health needs can be met with its current workforce.
- Counts and growth trends of licensed workers point toward the severity of the problem, but the *distribution* of the behavioral health workforce drives the crisis as well. “Behavioral health services” is an expansive category that includes a broad array of services across a continuum of prevention, crisis intervention, treatment, and recovery support, provided in diverse settings located in urban, suburban, and rural geographies to patients of every possible combination of race, ethnicity, wealth, and insurance status. Understanding the workforce needs of such a complex system is itself a daunting task. To demonstrate the inadequacy of simply comparing workforce supply to estimated demand for services consider that, nationally, 40% of psychiatrists work in exclusively cash-only practices,<sup>5</sup> making counts of licensed psychiatrists a poor indicator of access for low- and middle-income people.
- We also know that Illinois lags behind the U.S. average for availability of behavioral health professionals.<sup>10</sup> But as the University of Southern California Schaeffer Center for Health Care Policy & Economics is careful to point out in its analysis of the Illinois behavioral health workforce, the U.S. average is merely an arithmetic mean, not a validated benchmark for adequate workforce supply.
- Estimates of unmet behavioral health care needs:
  - In a 2017 survey 29% of Illinois adults who had experienced serious psychological distress in the past year reported unmet need and 33% of those respondents cited unaffordable costs as the reason for not receiving care.
  - 45.8% of the 1.6 million Illinois adults who have experienced a mental illness did not receive treatment.
  - An annual average of 799,000 people in Illinois aged 12 and older need but do not receive substance use disorder treatment at specialty facilities.

- National research indicates that only 9.1% of adults with co-occurring mental health and substance use disorders receive care for both and 52.5% received neither mental health care nor substance use treatment.
- Unmet need among youth:
  - Only 38.9% of the 121,000 Illinois youth aged 12-17 who experienced a major depressive episode received care.
  - 7.7% of people in Illinois over the age of 12 and 15.8% of young adults aged 18-25 have a substance use disorder.
  - Mental Health America estimates that over half of Illinois youth with depression receive no services and that three quarters of youth with severe depression do not receive consistent treatment.
  - 90% of youth attend a public school that fails to meet minimum recommended ratios for counselors, social workers, psychologists, or nurses.
- Unmet need in the criminal justice system:
  - People who report experiencing serious psychological distress are more likely to be arrested, to be on probation, and to be incarcerated.
  - Less than half of jail inmates with a diagnosed serious mental illness receive medication and less than a quarter receive counseling.
  - A federal court monitor overseeing the *Rasho v Baldwin* settlement found delays in treatment and backlogs in psychiatric evaluations driven largely by shortages of psychiatrists and other behavioral health staff.
- Unmet need among older adults:
  - Nearly 1 in 5 adults age 65 and over have one or more mental health or substance use disorder.
  - Between 2013 and 2019, depression in adults aged 65 and older increased from 13.4% to 14.5% in Illinois.
  - While most health care workers, including behavioral health specialists, encounter older adults in their practice, few are trained in geriatric mental health and SUD prevention and treatment:
    - Only 4.2% of psychologists surveyed by the American Psychological Association reported geropsychology as their primary focus, but 39% reported delivering services to older adults.
    - Most older adults are insured through Medicare, but its reimbursement rules deter access to psychiatric consultation during primary care visits.
- Unmet need in rural areas:
  - Rural counties in Illinois have an average of 1.6 psychiatrists per 100,000 residents compared to 12.6 in large urban counties and 10.5 in the state overall.
  - Rural counties have an average of 45.5 primary care physicians per 100,000 residents compared to a state average of 80.7.



- 30.3% of rural hospitals are in designated primary care shortage areas and 93.7% are in designated mental health shortage areas.
- One rural community mental health center reported that they have not been able to hire master's level or licensed staff for clinical positions at all since 2018.
- Hiring bachelor's level staff imposes extra supervisory duties on existing master's level clinicians, further depleting staff time for patient services. Lacking license-holders on staff also reduces service capacity and prevents the center from billing Medicare and commercial insurance.

The Illinois State Budget impasse from 2015 to 2017 exacerbated existing rural workforce shortages:

- Since the budget impasse, rural behavioral health providers have reported turnover as high as 60% and one-year delays in hiring for vacant positions.
  - Rural providers report being less able to absorb the cost of the state minimum wage increase, given current reimbursement rates from state programs and the lasting impact of the budget impasse on their finances.
- With over 55% of practicing psychiatrists over the age of 55, more psychiatrists are retiring each year than are graduating from psychiatry residency programs
  - Low reimbursement from Illinois Medicaid and commercial insurance are disincentives for psychiatrists to accept insured patients without significant additional funding from consumer out-of-pocket spending or public grant programs
  - Illinois has one of the lowest Medicaid-to-Medicare physician fee schedules in the nation and psychiatry reimbursement rates cover less than 50% of the cost of care
  - Commercial insurers reimburse psychiatrists less than primary care and other specialty physicians for services billed with the same CPT codes
  - Nationally, the number of psychiatrists serving public sector and insured populations declined 10% between 2003 and 2013<sup>87</sup> New models, including collaborative care and telehealth, demand new competencies Illinois' shortage of psychiatrists specializing in serving children and adolescents is especially acute. Eighty-one out of 102 Illinois counties have no child and adolescent psychiatrists, and the remaining 21 counties have only 310 child and adolescent psychiatrists for a population of 2.45 million children.<sup>90</sup> The conclusion Thomas and Holzer reached over ten years ago in their analysis of child and adolescent psychiatry shortages appears to hold true today: "market forces and public mental health policy during the past decade have not directed the limited number of child and adolescent psychiatrists to the areas of greatest need or even provided an equitable distribution."

Project ECHO is a model for improving the competence of primary care providers and other professionals. This model was developed by the

University of New Mexico where they found that, rather than treating a single patient at a time, improving the competence of primary care providers to address the specialty care traditionally provided by a specialist leads to dramatically improved access to high quality specialty care. At SIU School of Medicine, we have several ECHO's going on simultaneously, including an ongoing program to support providers in developing MAT clinics and providing basic psychiatric care. Participants for these ECHO's have spanned the entire state, including counties with no other providers as well as Emergency Room Physicians in Chicago inner-city hospitals.

During the pandemic, the State of Illinois and the Federal Government loosened restrictions on telehealth.

- This allowed SIU psychiatry to maintain 96% of our pre-pandemic outpatient volumes by providing services to people in their homes. SIU School of Medicine has served patients in 88 of the 102 counties during the pandemic.
  - Other specialties within SIU School of Medicine saw a dramatic increase in telehealth services as well with over 5000 of family medicine telehealth visits and almost 1000 internal medicine telehealth visits in the month of May.
- Patient satisfaction scores have climbed as our use of telehealth has risen at SIU School of Medicine.
- From mid-March to late-May, phone survey interviews were conducted with 2,295 SIU School of Medicine telehealth patients. Over 70% of those surveyed said they would like to continue to see their provider via telehealth after the pandemic.
- As the pandemic has worn on, we have continued providing almost 50% of our outpatient services via telehealth. We are currently providing service to people from Chicago and its surround communities to the Southern-most counties in Illinois. If the current restrictions are not made permanent, most of the people currently being served by SIU Psychiatry telehealth will, once again, lose access to psychiatric services.
  - From April-July, SIU School of Medicine patients with home addresses in Cook and the collar counties accessed telehealth services in the following areas: primary care, psychiatry, plastic surgery, pediatric genetics, neurology, and infectious diseases.

#### Potential Solutions:

1. We need to increase the number of people of color that we train to work in the behavioral health workforce.
  - a. Pipeline programs are particularly important. SIU has several pipeline programs where we reach into middle schools and high schools to get children interested and invested in careers in healthcare. We also have a MED-PREP program to help people of color get a Masters



- of Public Health in preparation for admission to medical school. This program has dramatically improved the diversity of physicians in our state and throughout the country. Expansion of this type of program will lead to
- b. For example, according to the most recent data from the American Association of Medical Colleges, 4% of psychiatry residents nationally are black. At SIU, 19% of our psychiatry residents are black. While SIU Medicine has an above average rate of black psychiatrists, it is clear that it is time to turn our state and national attention to increasing the black mental health workforce.
2. Recognizing that it will take years to increase the diversity of our workforce, we also need to immediately improve cultural competence and cultural humility of behavioral health providers so that we are better able to care for all people in our state.
  3. Need to learn to deliver care differently and have funding and policies that support those new ways of delivering care.
  4. Improve access to telehealth services for people in Illinois:
    - a. Require insurance reimbursement for telehealth services at the same rate as in-person visits.
    - b. Eliminate restrictions on patient location and payment for new patient visits.
    - c. Expand list of providers eligible for telehealth reimbursement.
    - d. Expand the definition of telehealth services to include “health care, psychiatry, mental health treatment, substance use disorder treatment, and related services to a patient, regardless of their location, through electronic or telephonic methods”.
    - e. Require health insurers to cover the costs of all telehealth services rendered by in-network providers to deliver any clinically appropriate, medically necessary services and treatments to insurer’s enrollees, and members under each policy, contract, or certificate of health insurance coverage.
    - f. Waive all utilization review requirements and pre-authorizations for telehealth services.
    - g. Limit cost sharing for telehealth services to the same amount required from patients for in-person visits from in-network providers.
    - h. Expanded broadband access throughout the state
  5. Create a model (like Colorado, Massachusetts, and others) to fund phone consultations by psychiatrists to primary care providers and other medical specialties.
  6. Incentivize collaborative care and integrated behavioral health care where mental health providers are working inside primary care and other medical specialty clinics
  7. Expand Project ECHO programs to help primary care providers improve their competence of treating less severe mental illness and Medication Assisted Treatment. This would create capacity with the mental health workforce to meet the needs of people with more severe illness.
  8. Expand funding for mental health professional training.
    - a. Some states fund physician residency positions through Medicaid or the state legislature (Nebraska, Michigan for example)

- b. Data shows that most physicians remain within 30 miles of where they completed their physician residency training. So investing in physician residency training programs is one of the most effective ways to build a physician workforce.
  - c. This particular solution is vitally important given that across the US we have more psychiatrists retiring from the workforce that we have graduating from psychiatry residency each year. We need to train larger numbers of psychiatrists and child psychiatrists to overcome this loss of workforce
9. Finally, fund the Behavioral Health Workforce Education Center described in the Behavioral Health Workforce Education Center Task Force Report presented to the Illinois General Assembly December 27, 2019.