resource settings has the potential to galvanize new investments in large-scale mental health initiatives.

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Providers' Knowledge of Diagnosis and Treatment Best Practices for Acute Myocardial Infarction (AMI): Evidence from India Using Clinical Vignettes

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Research Objective: Cardiovascular diseases (CVDs) are a leading cause of death worldwide, and 80% of CVD deaths occur in low- and middle-income countries (LMICs). The Global Burden of Disease Study estimates that CVDs contribute 28·1% of total deaths in India. Acute Myocardial Infarctions (AMI) make up a large share of these deaths. Early diagnosis and correct treatment of AMI is critical to preventing CVD-related deaths. This study aims to assess the competence of primary care providers in India to diagnose and treat AMI and examine differences between public and private sector providers.

Study Design: We conducted a cross-sectional study of healthcare providers' knowledge of diagnosis and treatment for AMI. Data collection took place in Odisha, one of the poorest states in India, from August 2019 to March 2020. Using data from vignette-based interviews with primary care providers in the public and private sectors, we assessed providers' knowledge of best practices in clinical care. The public sector providers within this study included physicians at government-run primary health centers, and the private sector providers were engaged in solo-practice, irrespective of medical qualifications. The vignette-responses were evaluated against standard treatment guidelines (STGs) for AMI at the primary care level.

Population Studied: 110 primary care providers working in Odisha, India a state with ~47 million people, of which 32.5% earn < $1.90/day and ~ 60% belong to indigenous or vulnerable social groups.

Principal Findings: Overall, providers demonstrated low levels of knowledge: only 67.27% diagnosed AMI correctly, and 0% recommended the correct treatment as per STGs. Providers seldom asked key diagnostic questions such as family and medical history (6.36% of cases) and the nature of the chest pain (10.91%) or results from diagnostic tests like ECG and EKG (30%), lipid profile (1.82%), or angiograms (3.64%). Private sector providers showed higher competence in making a correct diagnosis than public providers (difference of 32.73 percentage points). In line with STGs, 82.43% of providers referred AMI cases to hospitals, with more private than public providers making these referrals. 55.41% of providers prescribed at least one correct drug (in combination with unnecessary drugs). More private providers prescribed at least one correct drug than public sector providers. 44.74% of public providers prescribed only unnecessary drugs, without a single medicine recommended for angina.

Conclusions: Healthcare providers in Odisha, India, have low levels of knowledge regarding AMI diagnosis and treatment, with public providers showing lower competence than private providers.

Implications for Policy or Practice: Our findings indicate strikingly poor quality of care for AMI at the primary care level. The widespread misdiagnosis of AMI, the prescription of unnecessary drugs, and a lack of appropriate referral raise concerns for India's efforts to address rising rates of CVD. Our findings suggest addressing CVD in LMIC contexts is complex and requires improving the baseline knowledge of providers in both public and private sectors; which may be particularly relevant in contexts with little de facto regulation.

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HEALTH WORKFORCE

The Impact of Covid-19 on Certified Nursing Assistants in New York City: A Cross-Sectional Study

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Research Objective: In December 2020, the *New York Times* reported that nursing home (NH) residents and workers accounted for 38% of COVID-19 related deaths in the U.S. Despite this toll, research documenting the impact of the pandemic from a worker perspective is limited. Focusing on the experience of certified nursing assistants (CNAs), the primary providers of direct care to NH residents, this study examined the physical, emotional, and financial impact of COVID-19 and identified resource needs in the pandemic context.

Study Design: A phone survey was conducted between September and December 2020 with CNAs who are members of 1199SEIU, the largest healthcare union in the U.S. To be eligible, CNAs had to be union members and care for patients at NHs in New York City, Long Island, or the Lower Hudson Valley during the pandemic. The survey included 42 questions and focused on COVID-19 exposure, mental and physical health, family economic security, and workplace resources and training.

Population Studied: This study focused on 216 CNAs working for unionized NH employers in downstate New York.

Principal Findings: A total of 216 CNAs from 98 unique NHs participated in the study. 78% of participants were between 40–69 years old, 93% were women, 87% were Black, and 61% had more than

10 years of experience in NHs. In addition to their role as paid care providers, 81% reported providing care or financial support to family members. With regard to COVID-19 *Exposure*, 93% reported being tested since the beginning of the pandemic, with 33% testing positive. Significant majorities were "very concerned" about exposing themselves (75%), family members (86%), and patients (80%) to COVID-19 given the nature of their work. With respect to *Mental Health*, 76% reported feeling emotionally drained and 60% reported feeling fatigued on a regular basis. 52% said support dealing with stress and anxiety would be "very useful." Concerning *Family Economic Security*, 29% said the pandemic made it harder to pay for basic needs (e.g., food, rent, etc.) and 48% said it was harder to care for family members. Majorities said help accessing affordable housing (61%), paying for food (58%), and paying for work-related transport (52%) would be "very useful." With regard to *Workplace Resources*, 81% said they currently had enough PPE, and 33% reported having to provide their own PPE at some point during the pandemic. 92% experienced patient deaths in their unit or NHs during the pandemic, while 40% said services were made available to provide support in the grieving process. With respect to *Training*, most were "very interested" in training on stress management" (58%) and treating patients with COVID-19 (55%).

Conclusions: Our survey results show significant challenges and resource needs among unionized CNAs in downstate New York.

Implications for Policy or Practice: Unionized CNAs have significant resource needs in the pandemic context, and other data suggests that the needs of non-unionized CNAs may be even greater. To better support this workforce, action by public health officials and policymakers is warranted, particularly with respect to workplace safety and protection, mental health, compensation, and access to basic resources.

"We Have to Meet Those Clients Where They're at" - Michigan Behavioral Health Providers' Responses to Telehealth Policy Changes during COVID-19

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Research Objective: To understand the impact of state and federal policy changes during the COVID-19 pandemic on use and effectiveness of telebehavioral health based on provider experience,

Study Design: Between July and August 2020, researchers conducted one-hour interviews with 31 Michigan-based behavioral health providers from 15 counties. These semi-structured interviews included the following topics: (1) Experience with telebehavioral health prior to, and during, the pandemic, (2) Changes in cost of, access to, and quality of care between in-person and telebehavioral health services, and (3) Telebehavioral health's impact on providers and clients. The interviews were recorded, transcribed, and later analyzed with Dedoose™ software to identify common themes between responses.

Population Studied: Interviewees included a psychiatrist, psychologists, registered nurses, clinical social workers, mental health counselors, substance use disorder counselors, applied behavior analysts, and peer support specialists.

Principal Findings: Telebehavioral health provision increased during the pandemic, with all interviewees reporting providing telebehavioral health services - 19 for the first time. All interviewees agreed that newly-enacted state and federal policies made it legally and financially viable to continue safely providing services during the pandemic. Fourteen interviewees reported increased job satisfaction and decreased feelings of burnout. No interviewees reported a breach of health data as a result of using non-public facing audio-visual communications. Overall, interviewees agreed telebehavioral health services were at least as effective as in-person services. Clients with certain conditions (social anxiety, post-traumatic stress disorder) seemed to respond better to telebehavioral health services. Clients with other conditions (substance use disorder, developmental disabilities) responded less favorably.

Thirty interviewees reported clients were satisfied with telebehavioral health services, with some clients preferring them over in-person services. Twenty-eight reported telebehavioral health reduced or removed barriers that would have otherwise prevented these clients from receiving care, such as the need to arrange for transportation, childcare, or time off from work. This resulted in decreased no-show rates and more regular contact between providers and clients. Access to care for geographically isolated populations increased when audio-only telebehavioral health was authorized; these populations used to have to travel further for care, and often lacked high-speed internet and internet-connected devices necessary for audio-visual telehealth services.

Conclusions: Despite telebehavioral health's effectiveness and widespread client approval, interviewees expressed that their current work with telehealth was only possible because of recent policy changes. Should those policies revert back, providers may not be able to continue to provide these services. For some clients, such as those who are geographically isolated and unable to engage with anything but audio-only telehealth, reverting these policies would mean notable barriers and/or losing access to care entirely.

Implications for Policy or Practice: In Michigan, policy implications for both private and public insurances include continuing audio-only telehealth authorization and improving coverage of telebehavioral health by instituting service and reimbursement parity policies. Such policies could be enacted through Medicaid plan amendments or amendments to Michigan's Insurance Code. For federal policymakers, implications include amending HIPAA to improve acceptability of non-public facing audio-visual communications and extending certain