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

provisions of the CARES Act, such as allowing audio-only telehealth as a modality of last resort, through new laws and regulations.

Primary Funding Source: Institute for Healthcare Policy and Innovation.

The Impact of Gender and Sociodemographic Characteristics on Dentists' Practice Patterns, Employment Status, and Workforce Participation

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Research Objective: Gender diversification is rapidly occurring within the dental profession. Gender differences in practice choice (eg, employment vs practice ownership) and practice participation (eg, part-time vs full-time work hours) have been reported. It is important to understand how changes in the delivery system including workforce participation and preferences might impact the availability of services especially for underserved populations. The objectives of this study were to evaluate the variation in practice preferences among female and male dentists and to assess potential associations with socioeconomic and family factors.

Study Design: The current study used data from the Census Bureau's American Community Survey (ACS). The variables extracted describe dentists' sociodemographic characteristics including gender, age, race/ethnicity, presence of children or elders in the household, household income, and marital status, as well as dental practice characteristics such as employment status, practice setting, and work hours.

Population Studied: The 5-year Public Use Microdata Sample data (2014–2018) from the ACS were utilized. Person-level data collected through the questionnaire contain demographic, social, and economic information. The analytical sample consisted of 9993 dentists and 520,925 people living in the dentists' households. Survey data was weighted to generate unbiased estimates representative for the US population.

Principal Findings: Female dentists were younger (mean 43.3 years vs 53.6; $P < 0.001$), more racially and ethnically diverse (58.1% vs 78.6% White, non-Hispanic; $P < 0.001$), and proportionally more foreign-born (35.2% vs 17.7%; $P < 0.001$) compared to male dentists. Female dentists were more likely to report being employed (55.1% vs 34.8%; $P < 0.001$) or working part-time (less than 30 hours per week) in dental practice (15.5% vs 11.0%; $P = 0.001$) than male dentists. Female dentists with children were more likely to report being an employee (64.3% vs 52.8%; $P < 0.001$) and working part-time (19.5% vs 14.3%; $P < 0.001$) compared to female dentists without children in their care. Proportionally fewer female dentists left the workforce (ie, retired) in the past 12 months than male dentists (2.4% vs 3.6%; $P = 0.002$). Average income in the past 12 months was significantly lower ($P < 0.001$) for female dentists (mean = \$141,267; 95% Confidence Interval [CI] = \$ 135,452 -\$147,082) compared to male dentists (mean = \$185,923; 95% CI = \$135,452–\$147,082).

Conclusions: The data indicate that the dental workforce is diversifying in gender and by race/ethnicity. The data about dental practice by gender is consistent with the current literature; female dentists were significantly more likely to be employed than to be self-employed/a practice owner. This preference is consistent with evolving practice models including consolidations of smaller practices into group practices and changing business models for the profession. The wage gap by gender, which has been previously researched, is notable and difficult to explain.

Implications for Policy or Practice: The percentage of women entering and graduating from dental schools has increased over recent years achieving equity in numbers in dental schools in the US. Differences in employment status and workforce participation by gender are important preferences that should be monitored over time to ascertain if availability of services is affected by these trends.

Primary Funding Source: Health Resources and Services Administration.

Impact of Primary Care Usual Provider Type and Provider Interdependence on Outcomes for Patients with Diabetes

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Research Objective: Quality of diabetes care delivered to patients with different types of usual providers of care [i.e., physician, physician assistant (PA) or nurse practitioner (NP)] is similar. However, primary care (PC) providers often provide care to each other's patients (i.e., "share" common patients). The impact of patient sharing, or interdependence, is on quality of diabetes care is unknown. As a result, some providers and organizations hesitate to formalize patient sharing by creating multi-provider teams due to concerns about the impact of impact of such teams on quality of care. We sought to both 1) evaluate the association of usual provider type (physician or PA/NP) provider and 2) interdependence on outcomes for patients with diabetes.

Study Design: This patient-level cohort study used electronic health record data from 24 health system-affiliated PC practices in central North Carolina. Patients' usual PC provider was the provider most frequently seen during 2016 and 2017. Patient-level independent variables included demographic, medical complexity, and healthcare utilization (separate variables for PC, specialty, emergency department, and hospital). Provider panel-level variables [usual provider of care type (physician or PA/NP), panel size, and provider interdependence (# shared patients / # supplemental providers then