increased by restricting the cohort to those diagnosed with status epilepticus who had received a benzodiazepine. Excluding patients without benzodiazepine treatment underestimated the degree of undertreatment. Also, ESO may not be nationally representative; thus, generalizability is unknown because studies comparing ESO patients with the broader prehospital population are lacking.

This study suggests that reasons for the variation in care between emergency medical service agencies should be examined to improve the real-world prehospital care of patients with status epilepticus.

Elan L. Guterman, MD, MAS
James F. Burke, MD, MS
Karl A. Sporer, MD

Author Affiliations: Department of Neurology, University of California, San Francisco (Guterman); Department of Neurology, University of Michigan, Ann Arbor (Burke); Department of Emergency Medicine, University of California, San Francisco (Sporer).

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Corresponding Author: Elan L. Guterman, MD, MAS, Department of Neurology, University of California, San Francisco, 505 Parnassus Ave, M798 Box 0114, San Francisco, CA 94143 (elan.guterman@ucsf.edu).

Author Contributions: Dr Guterman had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. Concept and design: All authors. Acquisition, analysis, or interpretation of data: Guterman, Sporer. Drafting of the manuscript: Guterman, Sporer. Critical revision of the manuscript for important intellectual content: Guterman, Burke. Statistical analysis: Guterman. Administrative, technical, or material support: Sporer. Supervision: Burke, Sporer.

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Changes in COVID-19 Vaccine Intent From April/May to June/July 2021

Since May 2021, the US has offered COVID-19 vaccines to all adults, yet only 66% of adults were fully vaccinated by September 25, 2021. The Delta variant surge heightens the importance of vaccination.
To optimize outreach and understanding, we investigated the degree to which an individual's intent to vaccinate changes over time and assessing factors that relate to rising vaccine likelihood are critical. For example, whether individuals who are initially "unsure" or "unlikely" will eventually be vaccinated is unknown. Most studies of vaccine intent are cross-sectional and cannot assess these changes.

Using data from a nationally representative longitudinal study of adults in the US, we assessed individual-level change in vaccine intent and uptake between April 2021 and July 2021 and characteristics of individuals who reported an increase in vaccine likelihood or uptake.

Methods | The Understanding America Study (UAS) repeatedly surveyed a probability-based internet panel of approximately 9000 US adults aged ≥18 years. Panelists were recruited using address-based sampling, allowing for valid statistical inferences and avoiding coverage problems from convenience web-based panels. Internet-enabled tablets were provided if needed. Respondents received $20 per 30-minute survey time. Panelists were surveyed beginning March 10, 2020, initially biweekly and monthly after February 17, 2021, in English or Spanish about COVID-19. Overall, 89% of panelists consented to participate in the longitudinal survey. Each survey wave, about one-fourteenth (1/28 since February 17, 2021) of these consenting panelists were invited daily on a rolling basis to complete surveys over 2 weeks.

We analyzed 2 UAS waves, April 14, 2021, to May 25, 2021 (70% completion rate), and June 9, 2021, to July 20, 2021 (67% completion rate), focusing on respondents who were unvaccinated in April/May. For each wave, we asked panelists whether they received a COVID-19 vaccine; if they had not, they were asked “How likely are you to get vaccinated?” (response options: “very likely,” “somewhat likely,” “unsure,” “somewhat unlikely,” or “very unlikely”). We compared intentions in April/May with vaccination uptake or intentions in June/July and used robust Poisson regression to assess demographic predictors of vaccine intentions in June/July among respondents who were unsure, somewhat unlikely, or very unlikely in April/May. Analyses accounted for survey sampling weights, using 2-sided significance levels of .05, with significance defined as 95% CIs not containing 1 (SAS, version 9.4 [SAS Institute Inc]).

Participants provided written informed consent. The University of Southern California’s institutional review board approved the study.

Results | The April/May survey included 6052 respondents (including 2039 who were unvaccinated) and the June/July survey included 5839 respondents (5747 with vaccination/likelihood responses), and 1683 of these respondents (weighted N = 1967) also met the April/May inclusion criteria (reported being unvaccinated). The mean time between surveys was 56.5 (SD, 4.6) days. The analytic sample was 55.6% women (mean age, 44.9 [SD, 16.1] years).

The likelihood of vaccination among unvaccinated respondents remained the same or changed only somewhat for the majority of individuals between April/May and June/July (Table 1). Of the 564 participants who were somewhat or very likely to get vaccinated in April/May, 257 (45.6%) reported being vaccinated by June/July, 211 (37.3%) remained somewhat/very likely, and 96 (17.0%) became unsure/somewhat/very unlikely in June/July. Of the 1403 of 1967 respondents (71%) in April/May who were very or somewhat unlikely or unsure about getting a vaccine, 1199 (85.5%) remained so in June/July, 102 (7.3%) reported being vaccinated by June/July, and 101 (7.2%) became somewhat/very likely in June/July. Results for individual likelihood response categories are shown in Table 1. Factors significantly related to rising likelihood included being aged 50 to 64 years, being in an urban/suburban location, being Asian, and having a Democratic party affiliation (Table 2).

Discussion | For most individuals, reported likelihood of receiving the COVID-19 vaccine remained stable between April 2021 and July 2021. However, individuals who were unsure or somewhat/very unlikely in April/May 2021 and who were middle-aged, in an urban/suburban area, Asian, and Democrat were most likely to report being vaccinated or switching to somewhat/very likely by July 2021, suggesting that some groups are “moveable” toward vaccination. Structural barriers may remain because many individuals who were somewhat/very likely in April/May remained unvaccinated in June/July.

Study limitations include providing only English-language and Spanish-language surveys, self-reported metrics, and small sample sizes for subgroups.
Table 2. Change in Intent in June/July 2021 Among Unvaccinated Respondents Who Did Not Intend to Get a Vaccine in April/May 2021 (Weighted N = 1403)*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Participants who intend to get a vaccine in June/July 2021b</th>
<th>No.</th>
<th>Adjusted rate, % (95% CI)c</th>
<th>Adjusted risk ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td>778</td>
<td>14.3 (9.3-21.9)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td>626</td>
<td>13.6 (8.4-22.1)</td>
<td>0.95 (0.65-1.41)</td>
</tr>
<tr>
<td><strong>Age, y</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-49</td>
<td></td>
<td>906</td>
<td>11.2 (7.3-17.2)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>50-64</td>
<td></td>
<td>326</td>
<td>17.8 (10.4-30.7)</td>
<td>1.59 (1.03-2.46)</td>
</tr>
<tr>
<td>≥65</td>
<td></td>
<td>170</td>
<td>13.6 (7.8-23.8)</td>
<td>1.21 (0.71-2.08)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td></td>
<td>712</td>
<td>15.1 (9.7-23.5)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Some college</td>
<td></td>
<td>398</td>
<td>9.5 (5.8-15.6)</td>
<td>0.63 (0.39-1.03)</td>
</tr>
<tr>
<td>Bachelor’s degree or more</td>
<td></td>
<td>293</td>
<td>18.9 (10.8-33.2)</td>
<td>1.25 (0.80-1.96)</td>
</tr>
<tr>
<td><strong>Geographic location</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td>342</td>
<td>9.2 (4.8-17.7)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Urban/suburban</td>
<td></td>
<td>1062</td>
<td>21.2 (15.2-29.5)</td>
<td>2.31 (1.23-4.33)</td>
</tr>
<tr>
<td><strong>Race and ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td>198</td>
<td>10.5 (5.4-20.6)</td>
<td>0.92 (0.47-1.81)</td>
</tr>
<tr>
<td>Non-Hispanic Asian</td>
<td></td>
<td>28</td>
<td>36.5 (20.1-66.2)</td>
<td>3.20 (1.76-5.84)</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td></td>
<td>185</td>
<td>13.6 (7.7-24.2)</td>
<td>1.19 (0.67-2.14)</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td></td>
<td>942</td>
<td>11.4 (7.9-16.4)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>51</td>
<td>8.9 (2.6-30.5)</td>
<td>0.78 (0.22-2.70)</td>
</tr>
<tr>
<td><strong>Political affiliation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Republican party</td>
<td></td>
<td>630</td>
<td>10.6 (6.5-17.1)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Democratic party</td>
<td></td>
<td>216</td>
<td>19.4 (11.3-33.5)</td>
<td>1.84 (1.11-3.06)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>353</td>
<td>13.3 (8.3-21.3)</td>
<td>1.26 (0.79-2.01)</td>
</tr>
</tbody>
</table>

* Did not intend in April/May 2021: individuals who responded “unsure,” “somewhat unlikely,” or “very unlikely” to get a vaccine in April/May.

b Intend to get a vaccine in June/July 2021: individuals who responded “vaccinated” or “very likely” or “somewhat likely” to get a vaccine in June/July.

c Mutually adjusted for all the factors in the table.

d Race and ethnicity were selected as a category by the Understanding America Study survey developers because of known disparities in health metrics resulting from structural racism. Survey respondents self-reported responses to these survey questions. Race and ethnicity were selected in this analysis because racial and ethnic minority groups are known to be disproportionately infected by SARS-CoV-2, and because prior studies have shown lower COVID-19 vaccination rates among these groups. The “other” category refers to individuals who self-reported a different race (American Indian or Alaska Native [n = 6], Native Hawaiian or Other Pacific Islander [n = 1], or multiple races [n = 44]); sample sizes were too small to analyze separately.

d Individual characteristics were missing for less than 0.1% of respondents, with the exception of political affiliation, which was missing for 14.5% of respondents.

Although outreach, education, and reducing barriers may nudge “moveable” demographic groups toward vaccination, more intensive strategies (eg, mandates) may be needed for resistant groups.

**Peter G. Szilagyi, MD, MPH**
Kyla Thomas, PhD
Megha D. Shah, MD, MPH, MS
Nathalle Vizueta, PhD
Yan Cui, MD, PhD
Sitaram Vangala, MS
Arie Kapteyn, PhD

**Author Affiliations:** Department of Pediatrics, University of California at Los Angeles (Szilagyi, Vizueta); Dornsife College of Letters Arts and Sciences Center for Economic and Social Research, University of Southern California, Los Angeles (Thomas, Kapteyn); Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Los Angeles, California (Shah, Cui); Department of Medicine Statistics Core, University of California at Los Angeles (Vangala).

**Corresponding Author:** Peter G. Szilagyi, MD, MPH, Department of Pediatrics, UCLA, 10833 LeConte, MC 175217, Los Angeles, CA 90095 (pszilagyi@mednet.ucla.edu).

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**Author Contributions:** Drs Szilagyi and Kapteyn had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

**Concept and design:** Szilagyi, Shah, Vizueta, Vangala, Kapteyn.

**Acquisition, analysis, or interpretation of data:** All authors.

**Drafting of the manuscript:** Szilagyi, Shah.

**Critical revision of the manuscript for important intellectual content:** All authors.

**Statistical analysis:** Szilagyi, Shah, Cui, Vangala, Kapteyn.

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**Supervision:** Szilagyi.

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Platelet-Rich Plasma Injection vs Sham Injection and Tendon Dysfunction in Patients With Chronic Midportion Achilles Tendinopathy

To the Editor The recent study1 about injection of platelet-rich plasma (PRP) and tendon dysfunction in patients with chronic midportion Achilles tendinopathy confirmed findings of a recent meta-analysis.2 However, we believe that this article1 did not confirm or invalidate the effectiveness of PRP, which remains controversial. In addition to the lack of information about the exact composition of PRP used, the use of local anesthetic with lidocaine that may alter PRP effects,3 and failure to perform ultrasound-guided injection of PRP, this study would not confirm or invalidate the effectiveness of PRP, which requires quantification in publications on the efficacy of PRP injection, including standardized submaximal eccentric-based rehabilitation programs, as described for patellar tendinopathy after PRP injections.4

To conclude, we believe there is an urgent need for randomized clinical trials in this field that include precise lesion description, PRP characterization, ultrasound-guided injection, and an adapted concomitant rehabilitation program.

Vincent Gremeaux, MD, PhD
Eric Noël, MD
Jean-Francois Kaux, MD, PhD

Author Affiliations: Swiss Olympic Medical Center, Lausanne University Hospital, Lausanne, Switzerland (Gremeaux); Santy Orthopaedic Center, FIFA Medical Center, Lyon, France (Noël); Department of Physical Medicine, Rehabilitation and Sports Trauma, University Hospital of Liège, Liège, Belgium (Kaux).

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