Buprenorphine Opioid Treatment During the COVID-19 Pandemic

To the Editor To our knowledge, Nguyen et al\textsuperscript{1} were the first group to report on the consequences of enabling telehealth initiation of buprenorphine for management of opioid use disorders (OUDs) during the COVID-19 crisis. We read with much excitement their results, which showed a plateau in buprenorphine prescriptions while overall drug prescriptions declined between March 2020 and June 2020. We believe that the trends they report shed light both on the boon of flexible prescription via telehealth and on some potential oversights to address moving forward. These include ensuring treatment initiation and continuation for the most vulnerable patients, who might not have access to telehealth, and surveilling access to other OUD medications through the pandemic.

First, while the authors conclude that the change in policy could have allowed for retention in buprenorphine treatment, this might be a trade-off between insured and uninsured patients. That is, while insured patients seem to continue treatment using telehealth, cash payers were the only ones to see their number for buprenorphine prescriptions decline significantly as compared with Medicare, Medicaid and commercial plans (Figure 2\textsuperscript{1} and Table\textsuperscript{1}). Cash payers might encompass a subpopulation most vulnerable to the effects of this double pandemic. Among those most affected financially or otherwise by the pandemic (interruption of services, financial crises, etc) are users of multiple substances,\textsuperscript{2} those of lower socioeconomic status, those newly released from incarceration as part of the current decarceration efforts, and those dependent on now-fractured community safety nets.\textsuperscript{3}

Among those also excluded from the new telemedicine policies are patients with OUD who rely on in-person methadone clinics. To complement the work done by Nguyen et al,\textsuperscript{1} it would also be worthwhile to analyze how COVID-19 has affected the 350,000 Americans receiving methadone treatment.\textsuperscript{4} To better understand the impact of COVID-19 on restricting access to opioid treatment, future studies may wish to explore trends in other treatment modalities which require in-person monitoring.

In conclusion, Nguyen et al\textsuperscript{1} present an interesting first evaluation of recent policy efforts to facilitate OUD management in the wake of the ongoing COVID-19 pandemic. As they report, increases in the flexibility of prescription via telemedicine is invaluable to promote retention of patients in treatment and improve drug compliance. This will surely extend the past the current pandemic to include, for example, individuals living in rural areas or seeking an accelerated consultation. However, these trends seem to suggest other strategies will be necessary to prevent the most vulnerable individuals from falling through the cracks.

Mimosa Luigi, MSc
Michael Luo, MSc
Etienne J. P. Maes, BSc

Author Affiliations: Faculty of Medicine and Health Sciences, McGill University, Montreal, Quebec, Canada.

Corresponding Author: Etienne J. P. Maes, BSc, Faculty of Medicine and Health Sciences, McGill University, 3605 Rue de la Montagne, Montreal, QC H3G 2M1, Canada (etienne.maes2@mail.mcgill.ca).

In Reply We thank Luigi et al for their thoughtful comments highlighting the policy context of our study.\textsuperscript{1} Continued access to buprenorphine during the COVID-19 pandemic may be attributable to federal emergency guidelines allowing increased telehealth care.\textsuperscript{1}

We agree with their observation that many vulnerable populations with opioid use disorder (OUD), such as individuals with limited digital literacy and those who cannot afford broadband internet or have unreliable access, will require specific attention to achieve equal benefits from any transition to telehealth.\textsuperscript{2} Another particularly vulnerable population is criminal justice system-involved individuals who carry a disproportionately higher burden of both OUD and COVID-19. A study\textsuperscript{3} reported that only 4.6% of justice-referred clients received buprenorphine or methadone in specialty treatment vs 40.9% of those referred by other sources. Directed efforts to ensure that people receive assistance accessing online platforms, and communities have adequate infrastructure, will be necessary to support these populations during the pandemic.

As Luigi and colleagues note, prescriptions that were paid for out of pocket declined, compared with greater stability in prescriptions paid with Medicaid or private insurance. Many people who self-pay for care are uninsured or reluctant to use their health insurance. This plausibly relates to unprecedented job disruptions since March 2020. Rising uninsured rates will lead to greater cost-related barriers: a recent study\textsuperscript{4} found buprenorphine prescribers charged $250 or more as out-of-pocket fees for treatment initiation among cash-only patients. Although changes in the job market associated with COVID-19 may cause millions to lose their employer-sponsored health insurance plans, many of those losing insurance coverage can apply for Medicaid.\textsuperscript{5} As Medicaid expansion may provide safety nets to alleviate income and health insurance coverage losses, it will be helpful to disaggregate the trends in buprenorphine use across Medicaid expansion vs nonexpansion states in future research.

Luigi and colleagues rightly note that little is known about the effects the pandemic has had on methadone use via opioid treatment programs. Under the public emergency opioid treatment programs, health care professionals treating existing patients with methadone may dispense up to 28 days of take-home methadone dose; however, they cannot admit new patients with...
out a complete physical evaluation. Future research is needed to better understand the effects of these regulatory changes on treatment access via opioid treatment programs.

Our study\(^1\) contributes to a rapidly evolving policy landscape where there may be further opportunities to expand points of access to buprenorphine treatment via telehealth. These measures are especially worthy of consideration during a period of heightened overdose risk.

**Thuy D. Nguyen, PhD  
Brendan Saloner, PhD  
Bradley D. Stein, MD, PhD**

**Author Affiliations:** Department of Health Management and Policy, University of Michigan School of Public Health, Ann Arbor (Nguyen); Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland (Saloner); RAND Corporation, Pittsburgh, Pennsylvania (Stein).

**Corresponding Author:** Thuy D. Nguyen, PhD, Department of Health Policy and Management, University of Michigan School of Public Health, 1415 Washington Heights, M3234 SPH II, Ann Arbor, MI 48109-2029 (thuydn@umich.edu).

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5. Agarwal SD, Sommers BD. Insurance coverage after job loss—the importance of workplace loss compensation. *Health Aff (Millwood).* 2017;36(9):1603-1606. doi:10.1367/NEJMp2023312

**A Charge to Academic Chairs**

**To the Editor** The Research Letter by Odei et al\(^2\) demonstrates that a gender gap persists in US academic chairs despite increases in women faculty and residency leadership. A 1915 *JAMA* letter\(^2\) described a wartime need for women physicians:

> the demands of the military service have produced a deficiency in the supply of civilian practitioners which can be remedied only by utilizing the services of women physicians.... While at the close of the war men will tend to displace women physicians again to a greater or less extent, it may be taken for granted that the old order will never be reestablished in its entirety... if there are posts which a competent woman may fill as well as a competent man... it will be impossible for conservatism any longer to deny all opportunity to women. Yet Odei et al\(^2\) demonstrate that this prophecy did not hold true. In internal medi-

cine, for example, 40.8% of academic faculty and 16.8% of chairs are women.\(^3\)

Women faculty receive less start-up funding\(^3\) and lower compensation,\(^4\) and they experience publication bias.\(^5\) Their reduced rate of advancement is often attributed to competing societal expectations for care of children and aging parents. Societal expectations also influence academic health care organizations, with unconscious expectations of chairs to demonstrate certain leadership styles or profiles. Women may receive less mentorship and peer support, and are unsurprisingly more reticent about pursuing a chair position, a view reinforced by search outcomes.

Current chairs can change this. We must start by examining our own faculty and leadership, as well as the criteria we used in their selection, and encourage women and underrepresented minorities to become active stakeholders in their organizations and seek further opportunities. We must more actively provide visibility for contributions, give recognition for achievements, and identify networking opportunities for women and underrepresented minorities. We must examine and redress unwritten norms in academic chair selection as we lead search committees. We must advocate for a leadership culture that supports increased collaboration, encourages flexibility in work site and schedules, and honors personal time off. By strengthening diversity in experience, thought, style, gender, and race among our own faculty, we will create change in succession planning. Current leaders must make an active effort to understand the barriers faced by the current 16.8% of women internal medicine departmental chairs,\(^3\) and those that remain for other women. Women must demand consideration, demonstrate their merit, and highlight barriers to change.

**Laurie G. Jacobs, MD**

**Author Affiliation:** Department of Internal Medicine, Hackensack Meridian School of Medicine and Hackensack University Medical Center, Hackensack, New Jersey.

**Corresponding Author:** Laurie G. Jacobs, MD, Department of Internal Medicine, Hackensack Meridian School of Medicine and Hackensack University Medical Center, 30 Prospect Ave, Hackensack, NJ 07601 (laurie.jacobs@hmhn.org).

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5. Garrett L. The trouble with girls: obstacles to women’s success in medicine and research—an essay by Laurie Garrett. *BMJ* 2018;363:k5232. doi:10.1136/bmj.k5232

In Reply We thank Dr Jacobs for providing such a thoughtful commentary on our recent study,\(^1\) and concur with the perspective and recommendations put forward. We would like to underscore the key observation that the culture within aca-