

POLICY FORUM: INVITED COMMENTARIES & SIDEBARS

Hurricane Helene: Lessons Learned From a Medical Clinic Inside the Storm

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Hurricane Helene devastated Western North Carolina, disrupting health services and access to medications. This report highlights critical lessons from frontline providers in shelters and opioid treatment programs, emphasizing the importance of emergency preparedness and policy flexibility to support continuity of care during natural disasters.

Introduction

Hurricane Helene will likely be classified as one of the most devastating natural disasters in the recent history of the United States.

As rain and wind ceased on the afternoon of September 27th, 2024, local community members and organizations immediately went to work on the rescue and recovery effort. Four main barriers inhibited their progress: impassable roadways, limited or no communication via cell or internet services, lack of electricity, and a lack of running water. Thousands of first responders, government employees, medical staff, and volunteers stepped up to provide exceptional care. Each has a story to tell, with lessons learned.

These are some lessons learned from federally qualified health center and opioid treatment program providers in Buncombe County, North Carolina, one of the areas hit hardest by the storm.

Navigating Barriers

Shelters and Storm Preparedness

In the initial days following the storm, it was apparent that communication lines and transportation access were severely impacted. Due to down power lines, flooding, massive amounts of debris, and entire roads and bridges being washed away, many areas were simply inaccessible. Providers, patients, and staff were often not able to travel around the area or communicate with one another. Mountainous Western North Carolina had become an isolated island.

Emergency shelters were formed under the direction of local leadership as Buncombe County residents were rescued from damaged homes. Residents with medical conditions who needed electricity and clean water were redirected to the Asheville-Buncombe Technical Community College Ferguson Center Medical Shelter.

First responders appropriately realized that shelters needed health care providers to manage the acute and chronic conditions to limit strain on local overburdened emergency departments. Pre-existing connections with community paramedics via interactions with Buncombe County's post-overdose response team (PORT) seamlessly allowed individual paramedics to text local providers to ask for assistance at the emergency shelters. This cascaded into recruitment of multiple EMTs, nurses, social workers, therapists, nursing students, pharmacists and pharmacy residents, medical residents, providers, and volunteers to help quickly staff these shelters.

Policy recommendation. Each county or consolidated region should run a weather-related disaster response scenario once per year to discuss where shelters for displaced persons will be located, whether generators and potable water are available, and how county EMS will communicate with community health care members to staff these shelters.

Access to Prescription Medications

As roads slowly re-opened but utilities did not return, the major interstates of I-40 and I-26 continued to remain closed until about one week after the storm, when I-26 East was opened. Some medical providers made the decision to evacuate to other parts of the state or to nearby border states such as Tennessee, Georgia, or South Carolina to find reliable cell and internet service. When they logged into the electronic health record (EHR), they quickly realized that the system was operational, and patients were inundating it with portal messages.

Quickly, providers and staff set up a plan to respond to patients. Some patients had evacuated but had lost medications in the flood, left medication at home, or were just out of their medications because it was time for a refill. Providers electronically prescribed medications all over North Carolina and the United States. However, trying to set up telehealth appointments for patients proved incredibly difficult. Providers spent thousands of hours in the first few weeks after Hurricane Helene providing care to patients (via video, phone, and portal) that did not fit into the current compensation matrix.

Policy recommendation. There is variability in reimbursement of telehealth video and phone visits across insurers. Many insurers will only pay for telehealth visits if the provider and the patient are in the same state. Insurance companies need to instate "disaster rules" or billing codes that can be put into effect during emergency states to allow for flexibility in billing to coincide

with the activation of emergency refill policies. These regulations should be set up and communicated regularly to adequately prepare for natural disasters.

Identifying Patients with Substance Use Disorders—A Unique Population

Going without medications for chronic diseases like high blood pressure is worrisome, but facing lapses in treatment for opioid use disorders (OUD) can lead to severe withdrawal, return to use, and/or overdose. One of the authors, Dr. Fagan, personally saw four patients who returned to use in the aftermath of Hurricane Helene.

Grassroots efforts to identify patients without medications for opioid use disorder (MOUD) and in imminent danger of withdrawal came together across multiple office-based opioid treatment (OBOT) clinics and shelters. Patients in medical shelters were able to access short-term dosing of MOUD, namely buprenorphine, via onsite temporary pharmacies. Those not receiving care in the shelters were identified by clinical team members via pre-existing appointment schedules and registry lists.

During the first few days after the storm, medications often had to be called in to community pharmacies. Some pharmacies were damaged, while others simply could not operate. It was challenging to find pharmacies that were open, had buprenorphine in stock, and were able to accept verbal orders. Pharmacists and pharmacy residents created a living document to supplement the North Carolina (NC) Board of Pharmacy registry.¹

MOUD Dissemination Exceptions

There was frequent confusion for both prescribers and pharmacists around dispensing and refill regulations during a state of emergency. The NC Board of Pharmacy disseminated rules and regulations in an attempt to combat the hesitation to fill. For evacuated patients, prescriptions for MOUD were sent to out-of-state pharmacies unfamiliar to the patient. As of August 1, 2024, NC Medicaid does not require a copay for opioid antagonists or medications used to treat opioid use disorders²; however, NC Medicaid does not pay for medications sent to pharmacies in other states, which is another limitation for displaced individuals with limited resources.

Different from buprenorphine access in the traditional primary care OBOT setting, Opioid Treatment Programs (OTPs) are open 6 to 7 days a week, and common office hours are from 5:30 AM to Noon.³ OTPs provide access to OUD treatment—including access to MOUD, methadone, and buprenorphine—through an onsite pharmacy. Unlike medications filled at a community pharmacy that are often given 30 days at a time, people who start MOUD care at an OTP must initially present to the clinic daily to receive medications. Federal regulations and OTP/provider policy and practice have

rules on when patients can start having “take homes,” or medication dosages that they can take from the clinic pharmacy to self-administer at home.⁴ Take-home eligibility is evaluated by using 6-point criteria, including time in treatment, to determine a minimum required standard of medication safety.⁵

In practice, this looks like multiple patients coming to the clinic daily or every few days to access medication that supports their treatment goals and may, for many, be life-saving medication. It is important to note that when the medication is not accessible or prescribed, patients will experience a host of withdrawal symptoms that may include hot/cold flashes, gastrointestinal distress, and irritability.⁶

Within 24 hours of Hurricane Helene, access to OTPs was acutely altered. Road closures, gas station closures, and overall decreased access to transportation made travel to the clinic difficult for most patients and impossible for some. Some OTPs in the community experienced flooding damage while many experienced resource outages and were without power, water, or any internet/Wi-Fi services. In a very short amount of time, an alternate plan for providing access to MOUD out of OTPs was a priority. Collaboration and swift action were needed by multiple entities, including the State Opioid Treatment Authority (SOTA), the state regulatory body that accredits all OTPs in the state.⁷

The North Carolina SOTA granted an emergency exception that included multiple clinical provisions for swift action to support patient treatment access. This included providers to allow take-home doses of methadone and buprenorphine for patients who had not yet met the 6-point criteria, if needed to maintain access to treatment. SOTA also temporarily waived the requirement for patients to have a lockbox (usually required to receive take-home medication); instead, medication could be dispensed in a child-proof bottle. This was crucial with stores closed and access to lockboxes extremely limited in the period directly after the storm.

This emergency exception in practice meant that during the first week after the storm, a clinic would be able to provide some take-home doses to a patient who had been receiving MOUD daily to ensure medication access. This included delivering medications to patients in medical shelters utilizing the DEA rules of transportation already in place for dosing someone who is incarcerated. Together, these adaptations to the typical clinic structure and regulations allowed many patients to continue to access their treatment and not suffer from opioid withdrawal.

Ongoing Challenges

In the first 1 to 2 weeks after the storm, there were also undesired outcomes to medication administration. Since the supply of MOUD was unknown (unclear if shipments would reach clinical site), patients who typically receive a month of medications were at times only able to receive a 2-week prescription.

Buprenorphine and other controlled substances are part of the Suspicious Orders Report System (SORS), which can make ordering larger or unexpected quantities difficult. If a “suspicious” order is placed by a pharmacy, wholesalers halt delivery until documentation of increased need for MOUD has been provided. Pharmacies that were operational accommodated many patients and triggered the system frequently. This caused additional delays in inventory for MOUD. Exceptions or overrides were not available or offered, even in the state of emergency.

Policy Recommendations

- Have naloxone free and available for distribution from all EMS, emergency shelters, pharmacies, emergency departments, and primary care clinics during a disaster event.
- Make naloxone one of the first medications shipped into a disaster event. Have naloxone distribution and training for volunteers working in medical and non-medical capacities (like food and water distribution).
- Create a system to allow buprenorphine to be paid for by NC Medicaid via override codes in other states when the North Carolina governor declares a state of emergency.
- Remove buprenorphine from the Suspicious Orders Report System (SORS) as a life-saving medication to allow supply to be unrestricted at the community pharmacy level.
- Continued education on the importance of MOUD at all levels, from insurers to lawmakers to health care providers.

Conclusion

From the worst natural disaster that Western North Carolina has experienced, lessons have emerged about how to prepare for the next weather event. Areas for advocacy and policy change should be debated and implemented before the next hurricane season.

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