Addiction Treatment Networks Cannot Withstand Acute Crises: Lessons from 2021 Winter Storm Uri in Texas

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The week of February 14, 2021, will be forever ingrained in the memories of Central Texas residents. Winter Storm Uri blanketed the region in ice and snow, leading to devastating and unprecedented circumstances. Most residents lost electricity, and the water infrastructure in Austin and other cities collapsed. As roads became impassable, private and public transportation came to a grinding halt, and hundreds of thousands of people were unable to leave their homes. Businesses, medical clinics, pharmacies, and schools closed for days. Some acute care hospitals were forced to vacate and transfer patients elsewhere.

Among the most vulnerable during this catastrophe were people for whom addiction care providers and advocates across Austin have the privilege of caring: individuals with substance and opioid use disorders (OUDs). As medical providers and advocates who work to care for and empower those with addictive disorders, the authors of this manuscript saw firsthand how poorly marginalized and fragmented treatment services perform under the stress of a natural disaster.

Methadone and buprenorphine are lifesaving medications approved by the Food and Drug Administration for OUD treatment. Methadone must be dispensed by a federally and state-registered opioid treatment program (OTP), whereas buprenorphine may be prescribed by any provider registered with the Drug Enforcement Agency who has completed mandated "X-waiver" training and can be legally dispensed by a community pharmacy.

In Texas, our addiction treatment network is fragile. In addition to barriers experienced by our colleagues nationally, the absence of Medicaid expansion under the Affordable Care Act presents additional challenges. These include obstacles to meaningful reimbursement for pharmacotherapy, as well as the provision of vital and widely available wraparound services such as counseling, case management, and primary care. Waitlists for addiction care can be lengthy, sometimes 30 days or more in our experience. By law, every dose of methadone that is dispensed anywhere in the country must be carefully tracked. Any exceptions to this without layers of interagency approval subject providers to the potential of harsh legal penalties. While we have made progress as a state with support of policy makers, gaps remain. As the storm ravaged our community, patients were in the terrible position of standing by while a stressed system struggled to adapt.

In the case of methadone, clinic closures and legal restrictions meant that the emergency department (ED) became one of the few options for patients to receive a dose of this medication during the height of the storm. Some patients were able to arrange "guest dosing" from other nearby OTP clinics during limited hours or were able to obtain early "take-home" doses arranged prior to the storm. Others, however, were unable to obtain methadone and began to experience withdrawal, which profoundly increases the risk for recurrence and overdose [1].

We quickly learned the ED was an inadequate solution for these individuals because:

1. EDs were already overwhelmed caring for patients who receive dialysis, as all dialysis centers were shuttered during the storm;
2. Methadone dispensing laws normally require the patient to return to the ED daily for a single dose, and travel was severely impacted as transportation across Texas closed down;
3. Registering patients to receive care at the ED may have generated ED-related medical bills;
4. Some ED providers did not wish to take on the perceived burden of dispensing methadone;
5. EDs and hospital pharmacies did not have the bandwidth to adapt to the quickly changing emergency regulations; and
6. Some hospitals did not stock enough medication to balance inpatient needs with take-home dispensing.

Regulatory hardships also limited access to buprenorphine. Patients could only receive a prescription from a waivered provider and were then tasked with finding a pharmacy to fill a prescription before the storm, all while pharmacists scrutinized prescription monitoring program histories and insurers blocked early refills. Even under normal circumstances, it is challenging for patients to find a community pharmacy that has buprenorphine in stock. A recent secret shopper study in Texas found that only 42 percent of pharmacies were prepared to dispense even a 1-week supply of buprenorphine [2].

Transportation challenges during the storm also affected patient access to buprenorphine. Community health paramedics in the city of Austin were able to dispense bridge buprenorphine for a limited duration for some patients, but these calls for service were prioritized below other acute medical and trauma responses. For providers who attempted to navigate patients and their prescriptions to available pharmacies during the storm, the inequitable everyday barriers to addiction care became a dangerous maze.

Many of the people we serve rely on hourly work to afford access to treatment. In Austin, people were out of work for a week or more, which, for many, meant not having the funds necessary to obtain care. This led to numerous instances of healthcare providers attempting to walk patients through smartphone applications for medication coupons while the patients were experiencing agonizing withdrawal symptoms.

As result of this harrowing experience, we learned the following:

1. The current opioid treatment program model for accessing methadone significantly increases treatment barriers and is unable to meet patient needs during a natural disaster or acute crisis. The chokehold on the supply chain became highly visible during the Winter Storm Uri disaster, as the only sites legally allowed to dispense methadone (OTPs) were abruptly closed. To prevent such a breakdown in the future, contingency plans must include a wide array of dispensing sites, which may include EDs and community pharmacies. In fact, permitting community pharmacies to dispense methadone for OUD treatment under normal conditions is standard in many countries and would substantially decrease the transportation burden for patients in the United States [3].
2. The regulatory environment around prescribing buprenorphine for OUD treatment is a major barrier. This includes the "X-waiver" training requirement that mandates a minimum of 8 hours of postgraduate training. Dismantling the X-waiver requirement is widely supported by numerous national and state-level professional societies and advocacy organizations and would increase the availability of this mortality-reducing medication, especially during public emergencies, when a limited prescriber pool is highly detrimental [4,5].
3. Emergency declarations put forth by state governments must include sweeping provisions for ensuring continuity of care for those engaged in methadone or buprenorphine treatment.
4. We must develop robust, value-based approaches to addiction care and no longer rely on expensive fee-for-service or charity-based models. In the setting of an emergency, we must ensure access to a sustainable source of medications regardless of a patient's ability to pay.
5. Many of our solutions during Winter Storm Uri relied on a patchwork of informal networks. Our bootstrap strategies and knowledge must be part of fundamental considerations during natural disasters and beyond. The systems dysfunction we observed is a direct result of decades of under-resourcing the addiction medicine community. We must commit to making infrastructure investment for substance use disorders a high priority.

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6. The health care community must continue making progress toward increasing education and decreasing stigma for people with substance use disorders. During the storm, patients with other diagnoses such as diabetes were met with an abundance of last-minute resources to ensure continuity of care. Unfortunately, we cannot say the same for those with substance use disorders, despite addiction being a treatable chronic medical condition.

More than 1 week after the storm, we were still surveying the damage and unable to reach some of our patients. Due to the absence of interoperability across electronic health records and robust confidentiality standards for those receiving addiction care, we may never know the true losses experienced by our community. The experiences we describe occurred in Austin, but are not unique to our area. Major natural disasters can, and will, happen elsewhere. Policy makers and community leaders across the nation should learn from Winter Storm Uri.

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