2020 OPIOID USE DISORDER AND TREATMENT NEEDS

Maine

3.5% of state residents have Opioid Use Disorder

41,102 state residents with Opioid Use Disorder

Current Estimate

24,816 patients without access to treatment

13,647 patients receiving buprenorphine
2,640 patients receiving methadone
16,286 total patients with access to treatment

Projection*

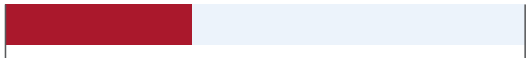
14,034 patients without access to treatment if existing providers treat more patients

27,293 patients receiving buprenorphine
3,300 patients receiving methadone
30,593 total patients with access to treatment

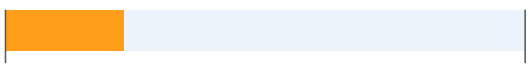
**Projection assumes buprenorphine prescribers double their number of patients and opioid treatment programs operate at full capacity.*

Driving Time to Nearest Treatment

Buprenorphine: **11 minute state average**



Methadone: **56 minute state average**



1,491 total overdose deaths; **32** per 100K (2016-2019)

1,264 opioid-related overdose deaths; **27** per 100K (2016-2019)

1% of the population speaks limited English;
1% of the population speaks Spanish;
1% of the population speaks another language

10 opioid treatment programs (OTPs) with **2,640** methadone patients; **223** per 100K residents

Prescribers in Maine, 2020

8,587 total prescribers in the state; 10% have a buprenorphine waiver (7% in 2018)

309 active* buprenorphine prescribers with a 30-patient limit

249 active* buprenorphine prescribers with a 100-patient limit

73 active* buprenorphine prescribers with a 275-patient limit

**An active prescriber is defined as the primary buprenorphine prescriber for at least one patient episode during the year.*

Strategies to Meet Demand for Treatment

Increase prescribers: Adding **635** new waivered prescribers would more than double the active prescribers and fill **10%** of the current treatment gap of 24,816 people, if new prescribers treat 4.1 patients each (the state average for 30-waivers). One potential source of new prescribers is the 333 inactive prescribers that already have a waiver to prescribe buprenorphine.

Increase prescribers and treat more patients: Active prescribers would have to treat 3 times as many patients to fill the treatment gap. If active prescribers doubled their number of patients, adding **304** new waivered prescribers would fill **18%** of the projected treatment gap of 14,034 people, if new prescribers treat 8.2 patients each (twice the state average for 30-waivers).

Other promising strategies: Engage health plans in prescriber outreach; expand medication for OUD (MOUD) in health centers, jails, prisons, EDs, hospitals, primary care, and addiction treatment programs, expand telehealth; coordinate with community partners, community health workers and peer recovery workers; remove state regulatory barriers to MOUD prescribing; ensure pharmacies stock MOUD.

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SUMMARY OF METHODS

See the methodological appendix for more details

Data sources. We used 2016–19 county drug overdose death data (for people ages 12 and older) from all drugs and from opioids from the CDC WONDER Multiple Cause of Death data. Data on languages spoken are from the Agency for Healthcare Research and Quality's Social Determinants of Health database. Driving estimates show the estimated driving time from 2016 county population–weighted centroids (published by the Missouri Census Data Center) and DC ward centroids (estimated from DC block centroids from Open Data DC) to the nearest opioid treatment program (OTP) and buprenorphine-waivered prescriber from the Drug Enforcement Administration (DEA) Active Controlled Substances Act Registrants Database.

Opioid use disorder (OUD) estimates. To estimate the demand for treatment, we calculated county OUD rates by averaging two estimates based on different methodological approaches. For the first, we started with substate estimates of past-year pain reliever use disorder (PUD) and heroin use for people 12 and older from the combined 2016 to 2018 National Survey on Drug Use and Health (NSDUH) substate data. We adjusted these estimates for recent trends and the share of people who have heroin use only but not PUD. We then used regression models to predict county-level rates as a function of explanatory variables that have an empirical relationship with OUD (Alzeer et al. 2017; Paulozzi et al. 2017). For the second OUD estimates, we multiplied the estimated NSDUH-based county estimates by a scalar representing the relationship between an NSDUH-based OUD rate, known to be biased downward, and a more accurate OUD rate based on a capture-recapture analysis of seven linked Massachusetts administrative databases (Barocas et al. 2018). We averaged these two estimates to compute county OUD rates and counts.

Treatment capacity and gap estimates. To estimate buprenorphine treatment capacity, we drew on 2018 IQVIA Real-World Longitudinal Prescription data, analyzed and published by the RAND Corporation's Opioid Policy Tools and Information Center. These data contain information on active buprenorphine prescribers, defined as the primary buprenorphine prescriber for at least one patient episode during the year, and buprenorphine patients by prescriber county. We also use the Drug Enforcement Administration's Active Controlled Substances Act Registrants Database, which includes information on all prescribers with a waiver to prescribe buprenorphine and their patient limit (30, 100, or 275). We calculated a lower bound of county treatment capacity as the number of patients currently receiving any buprenorphine treatment in the past year plus the current number of methadone patients at OTPs. We computed an upper-bound estimate based on a projected increase if all buprenorphine prescribers doubled their number of patients, or if counties with no active prescribers added 10 new prescribers, and OTPs operated at full capacity, assuming they currently operate at 80 percent capacity. To compute the number of people with OUD who do not have access to buprenorphine or methadone treatment in their county, we subtracted the treatment capacity in each county from the estimated number of people with OUD, with separate estimates for low and high treatment capacity. We assumed that all people with OUD seek treatment.

Strategies to meet demand for treatment. We computed the estimated number of additional 30-waivered buprenorphine prescribers needed per county to achieve capacity to fill the lower- and upper-bound estimates of the treatment gap, assuming new prescribers treat the estimated state average number of patients per 30-waivered prescriber for the lower bound and twice that for the upper bound. We present strategies to meet demand for treatment, showing a range using the lower and upper estimates of the treatment gap and the treatment capacity. In cases where the number of new prescribers needed would be more than double the number of current buprenorphine prescribers, we present an alternative, more feasible strategy of doubling the number of active prescribers or adding 10 new prescribers. In these cases, we present the share of the treatment gap that would be filled.

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