Complete Title: Nudges and Incentives to Enhance the Opioid Treatment Workforce

Short Title: Nudges and Incentives to Enhance the Opioid Treatment Workforce

Sponsor: National Institute on Drug Abuse (NIDA)

Protocol Date: May 20, 2021

NCT03834025

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National Institute on Drug Abuse (NIDA)
Three White Flint North

11601 Landsdown St

North Bethesda, MD 20852

Study Principal Investigator: Marisa E. Domino, PhD
The University of North Carolina at Chapel Hill

Cecil G. Sheps Center for HSR

725 Martin Luther King Jr Blvd

Chapel Hill, NC 27599-7590

Phone 919-966-3891
email: domino@unc.edu

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Lead Investigator:

Marisa E. Domino, PhD

The University of North Carolina at Chapel Hill

Protocol Version: 1.0

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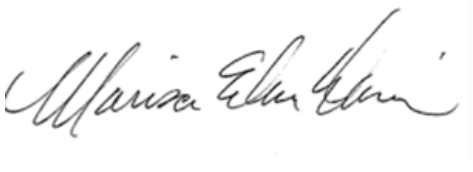
I confirm that I have read this protocol and understand it.

Principal Investigator Name: Marisa E. Domino

Principal Investigator Signature: 

Date: 5/20/2021

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ABBREVIATIONS AND DEFINITIONS OF TERMS

Abbreviation	Definition
PCP	**Primary care provider**
ECHO	**Extension for Community Healthcare Outcomes is a model of professional development that uses video conferencing technology to bring experts into even the most rural areas to support primary care providers**
MAT	**Medication-assisted treatment. The term Medications for Opioid Use Disorder (MOUD) has generally replaced MAT in its reference to the set of medications, although the role of psychosocial therapy is different between the two terms. We will generally use MOUD going forward but the term MAT is used herein for historical accuracy.**
MOUD	**Medications for Opioid Use Disorder**

PROTOCOL SYNOPSIS

Study Title: Nudges and Incentives to Enhance the Opioid Treatment Workforce	
Funder	NIDA
Study Rationale	Opioid overdoses currently claim the lives of 115 Americans per day. This epidemic is alarming, not just in its effects on the lives of individuals and families, but also on the light it has shined on the disturbing lack of treatment options in many areas. A number of effective treatments are available for opioid use disorder, but many require special training beyond a professional degree. In addition, the complex comorbidities and life circumstances faced by those with an opioid use disorder can deter many providers from investing the time needed to learn how to diagnose and treat individuals needing these services. To date, of North Carolina's 8087 primary care physicians, 4669 nurse practitioners, and 4237 physician assistants, only 785 (<5%) have undergone the waiver training required to provide medication assisted treatment (MAT) for opioid use disorder, a miniscule number of North Carolina's primary care workforce. Many waiver-trained providers are not yet prescribing, due in part to the lack of on-going education or support, so the effective rate of treatment provision is substantially lower than 5%. Further, only one-fifth of NC's zip codes have a waiver-trained provider. ECHO is an evidence-supported hub-and-spoke model of professional development that uses video conferencing technology to bring experts into even the most rural areas to support primary care providers. ECHO for MAT is program in NC that uses the ECHO model to develop a provider workforce that is equipped to provide MAT to those in need of treatment, preventing further accidental deaths from overdose. The time commitment required to develop MAT proficiency can prove to be a barrier to take up since provider time participating in ECHO may represent lost revenue from not seeing patients. This challenge can especially prohibit participation from small and rural practices, often where treatment is most needed. This research project will conduct a pilot study to examine the extent to which informational nudges incorporating specific information from a provider's community into recruitment materials (Aim 1) and financial incentives (Aim 2) affect participation in ECHO MAT by primary care providers. Through these estimates, this study will contribute much-needed information on the incentives that can be used to create a behavioral health workforce that is ready to meet the challenges of the opioid epidemic.

Study Objective(s)	Aim 1: To estimate the influence of informational nudges on the engagement of primary care providers in an opioid treatment learning collaborative to address the opioid overdose crisis. Aim 2: To estimate the influence of financial incentives on the participation intensity of primary care providers in an opioid treatment learning collaborative to address the opioid overdose crisis.
Study Design	The study is designed to be implemented in two phases. Phase 1 is the recruitment phase. Providers will be randomized to receive recruitment letters and emails from 1 of 4 conditions. Randomization for this phase will occur at the practice level, as determined by provider address. Participants that contact the study team and enroll in the study will begin Phase 2 of the study. In Phase 2 of the study participants will be randomly assigned to rewards for participation in ECHO MAT learning collaborative. Their participation in the learning collaborative will be tracked. Phase 2 of the study is a pilot.
Subject Population **key criteria for Inclusion and Exclusion:**	Inclusion Criteria 1. Licensed practicing Primary Care Provider (MD, DO, PA, NP) 2. Currently practicing in NC, not currently participating in ECHO MAT Exclusion Criteria 1. Another member of the same practice is already enrolled in the study (one provider per practice in Phase 2) 2. Active participation in The University of North Carolina at Chapel Hill (UNC) ECHO Collaborative at beginning of study
Number of Subjects	Up to 80 to achieve at least 20 in each reimbursement arm
Study Duration	Each subject's participation will last six months with the exception of participants who had not completed as of 3/9/2020 whose participation was extended by 3 months due to decreased learning collaborative sessions resulting from COVID-19. The entire study is expected to last up to two years
Study Phases **Screening** **Study Treatment** **Follow-Up**	(1) Recruitment: recruitment materials (letters or emails) sent once randomized to 1 of 4 conditions. Once participant enrolls, then (2) Randomization to 1 of 3 study arms: enrolled participants are re-randomized to 1 of 3 levels of reimbursement to estimate the influence of financial incentives in participation in learning collaboratives to address the opioid overdose crisis. Participation in learning collaboratives over 6 months will be

	tracked. Participation in learning collaboratives will be tracked over 9 months for participants who did not complete as of 3/9/2020 due to the COVID-19 pandemic.
Safety Evaluations	The risk to participants is minimal.
Statistical and Analytic Plan	In Aim 1, we anticipate starting with a random selection of 600 providers from the list of eligible NC providers generated from the NPI Registry, limiting to primary care providers identified through taxonomy codes, which gives more than 90% power to detect a ten percentage point difference in the binary outcome, response to study recruitment. We will use binary models (logit, linear probability models) to examine response to recruitment as a function of study arm, controlling for provider type and county fixed effects. For Aim 2, we will randomly recruit up to 80 providers as needed to have at least 20 providers per arm enrollees for this phase of the pilot (20 providers per arm). The outcome to be monitored for Aim 2 is the number of ECHO sessions attended in the 6 months following randomization. Because this is a pilot study, the sample size is not powered for the primary outcome, number of ECHO clinics attended. We will conduct a negative binomial or other count data model (depending on statistical tests) of the number of sessions as a function of financial incentive arm to estimate the effect of financial incentives on participation.
DATA AND SAFETY MONITORING PLAN	The risk to participants is minimal, and this does not meet the definition of a clinical trial, thus there is no data safety monitoring plan.

1 BACKGROUND AND RATIONALE

The major goals of the project are:

Aim 1: To estimate the influence of informational nudges on the engagement of primary care providers in an opioid treatment learning collaborative to address the opioid overdose crisis. Primary care providers in North Carolina, including physicians, nurse practitioners, and physician assistants, will be randomly assigned to receive either a pro-social recruitment approach for participating in the UNC ECHO MAT intervention or standard recruitment practice. Treatment assignment will provide pro-social information, including customized figures on the opioid use epidemic in the provider's region and the degree of the provider shortage in their region. The comparison arm will include a standard approach to recruitment that does not contain a pro-social recruitment message. Analysis of this data will provide estimates of the degree of responsiveness of providers to informational nudges.

Aim 2: To estimate the influence of financial incentives on the participation intensity of primary care providers in an opioid treatment learning collaborative to address the opioid overdose crisis. At the second stage, providers agreeing to enroll in the program will be re-randomized to one of three levels of reimbursement for time spent participating in the UNC ECHO MAT intervention. Analysis of this data will provide causal estimates of the degree of responsiveness of provider participation intensity to financial incentives. A sub-aim will examine whether the effect of incentives on participation intensity varies between the pro-social recruitment group and status-quo recruitment group. The results from this study will inform the feasibility and design of a full-scale trial testing the effects and cost-effectiveness of approaches to address the shortage of adequately trained primary care clinicians, providing urgently needed information on best practices in developing the health care workforce to treat individuals and communities most affected by the opioid crisis.

1.1 Introduction

This project seeks to examine a critical barrier to optimizing the health care workforce for the treatment of opioid use disorders. Without a dramatic increase in the number of primary care providers trained and comfortable with the many nuances of prescribing medication-assisted treatment (MAT), the staggering increases in opioid overdose deaths will continue to skyrocket. However, Drug Addiction Treatment Act (DATA) 2000 waiver training alone is not enough to facilitate prescribing for patients who desperately need services; an estimated 40% of physicians with waivers do not initiate MAT prescriptions. To address this problem, North Carolina developed a learning collaborative framework to promote MAT training. Learning collaboratives have been shown to be an efficacious approach to increase utilization of MAT, but engagement among providers in North Carolina has been low. To date, the need to encourage provider collaborative participation at scale has not been addressed. This is the critical problem focused on in this study.

The death rate from accidental opioid overdoses continues to climb at an alarming rate, with overdose deaths in 2016 almost five times the number from 1999. The daily death rate from opioid overdoses in the U.S. alone is now estimated at 115, so every day that evidence-based treatment is not available leads to more preventable deaths. North Carolina is one of the states with both an opioid overdose death rate greater than the national average (11.9 vs 10.4 deaths per 100,000, age-adjusted)

and a rate of increase in opioid overdose deaths greater than the national average (19% vs. 16%). North Carolina is also one of four states with an Agency for Healthcare Research and Quality (AHRQ) funded Extension for Community Healthcare Outcomes (ECHO) MAT learning collaborative available to primary care practices, but engagement among providers is low. While the main barriers to engagement are incompletely understood, recent evidence from provider interviews conducted by the study team in December 2017 and January 2018 suggest that one substantial barrier is the time required for weekly ECHO clinics.

1.2 Name and Description of Investigational Product or Intervention

Receipt of recruitment letter is the Intervention for Aim 1.

Randomized to one of three levels of financial reimbursement for their time in the ECHO sessions is the intervention for the second level of the study.

1.3 Non-Clinical and Clinical Study Findings

Potential Benefits. This study seeks to determine the extent to which financial incentives and informational nudges increase the participation of providers in a learning collaborative to support the expansion of MAT, thereby increasing the percentage of physicians, who get DATA-2000 waiver training and certified to provide MAT, who go onto implementation this lifesaving evidence-based practice in underserved counties.

Potential Risks. The potential risks of the intervention are minimal and patients in the care of these medical practices may benefit by having more decision-making involvement in their care and access to needed MAT. There is a small risk of breach of confidentiality. Procedures will be taken to minimize the possibility of a breach in confidentiality. No subjects will be identified in any publication or report of this study. There is no medical risk or risk of physical discomfort from this study.

2 STUDY OBJECTIVES

This research project will conduct a pilot study to examine the extent to which informational nudges incorporating specific information from a provider's community into recruitment materials (Aim 1) and financial incentives (Aim 2) affect participation in ECHO MAT by primary care providers. Through these estimates, this study will contribute much-needed information on the incentives that can be used to create a behavioral health workforce that is ready to meet the challenges of the opioid epidemic.

2.1 Primary Objective

Aim 1: To estimate the influence of informational nudges on the engagement of primary care providers in an opioid treatment learning collaborative to address the opioid overdose crisis. Primary care providers in North Carolina, including physicians, nurse practitioners, and physician assistants, will be randomly assigned to receive either a pro-social recruitment approach for participating in the UNC ECHO MAT intervention or standard recruitment practice. Treatment assignment will provide pro-social information, including customized figures on the opioid use epidemic in the provider's region and the

degree of the provider shortage in their region. The comparison arm will include a standard approach to recruitment that does not contain a pro-social recruitment message. Analysis of this data will provide estimates of the degree of responsiveness of providers to informational nudges.

Aim 2: To estimate the influence of financial incentives on the participation intensity of primary care providers in an opioid treatment learning collaborative to address the opioid overdose crisis. At the second stage, providers agreeing to enroll in the program will be re-randomized to one of three levels of reimbursement for time spent participating in the UNC ECHO MAT intervention. Analysis of this data will provide causal estimates of the degree of responsiveness of provider participation intensity to financial incentives.

2.2 Secondary Objective

A sub-aim will examine whether the effect of incentives on participation intensity varies between the pro-social recruitment group and status-quo recruitment group.

3 INVESTIGATIONAL PLAN (brief overview)

3.1 Study Design

In the first level of the study, providers will be randomized to receive one of two different recruitment letters. The receipt of the letter is the intervention for Aim 1. We will follow providers for up to 6 months after the mailing of the recruitment letters to monitor whether they attempted to sign up for the ECHO learning collaborative. This is the primary outcome for Aim 1.

Among the providers who contacted the study coordinator with interest in participating in the ECHO MAT learning collaborative (up to 80 of the providers), we will obtain consent to participate in the second level of the study, where providers will be randomized to one of three levels of financial reimbursement for their time in the ECHO sessions. This is the intervention for the second level of the study. We will monitor the number of sessions attended over 6 months from enrollment (9 months from enrollment for participants who did not complete as of 3/9/2020). This is the outcome for the second level of the study. We will send a letter to inform participants on how much they have participated and, if applicable, their incentive amount.

We may ask up to 44 of the study participants to participate in key informant interviews once their participation in the study has ended (6 months after enrollment). We will also contact a few individuals who initially indicated they were interested in participating, but then did not complete the consent process. We hope to learn why they did not complete the enrollment process.

We will contact study participants to notify them that we will look up their Waiver 2000 status (this is available through the DEA and publicly available on SAMHSA's website). We will not post or publish individual provider specific information on Waiver status.

We will use Medicaid claims data and ECHO learning collaborative participation data for the participants in our study to examine if the interventions in phase 1 or 2 have changed their MAT prescribing behavior, or their participation in ECHO MAT learning collaboratives.

Recruitment: Primary care providers will receive recruitment letters and may receive emails and phone calls based on the recruitment condition they are assigned to.

Randomization:

Phase 1: Primary care providers will be randomized by practice to 1 of 4 study arms. Computerized randomization will assign practices to study arms, practices and primary care providers will have an equal chance of being randomized to each study arm.

Phase 2: Eligible participants will be randomized to the Phase 2 study arm upon enrollment in the study. Randomization will be assigned using a predetermined randomly ordered list of study condition assignments. Upon enrolling in the study, the participants will be assigned to the condition that is next on the list. Participants will have an equal chance of being randomized to each study arm.

3.2 Allocation to Treatment Groups and Blinding (if applicable)

Participants are randomized to receive 1 of 4 recruitment materials. Once enrolled, participants are then randomized to receive 1 of 3 financial reimbursements for attendance in ECHO sessions

3.3 Study Duration, Enrollment and Number of Subjects

Each subject's participation will last six months (nine months for subjects who did not complete as of 3/9/2020 due to the complex practice environment experienced by providers during the start of the COVID-19 pandemic).

The entire study is expected to last up to two years.

Total number of subjects will be up to 80 as needed to achieve at least 20 subjects in each of the 3 financial reimbursement groups.

3.4 Study Population

Inclusion Criteria

1. Licensed practicing Primary Care Provider (MD, DO, PA, NP)
2. Currently practicing in NC, not currently participating in ECHO MAT

Exclusion Criteria

1. Another member of the same practice is already enrolled in the study (one provider per practice in Phase 2)
2. Active participation in The University of North Carolina at Chapel Hill (UNC) ECHO Collaborative at beginning of study

4 STUDY PROCEDURES (what will be done)

Once a provider is enrolled a schedule of weekly online live UNC ECHO clinic sessions will be sent from the UNC ECHO study team. Attendance is noted at each session and a summary of the prior months' attendance record is sent to the Principal Investigator monthly, indicating the number of hours spent in training and the reimbursement for those sessions. The appropriate dollar amount will be paid to the participant through a reloadable Visa gift card.

4.1 Subject Completion/ Withdrawal procedures

A primary care provider (subject) can participate in as many or as few ECHO MAT sessions as they like during the six-month enrollment in the Nudges study (nine month enrollment for participants who do not complete as of 3/9/2020), and can continue to participate in ECHO MAT even after completing the Nudges enrollment period. Nudges enrollment is based only on time since initial enrollment. A subject may withdraw (or be withdrawn) from the Nudges study for any reason. The reason for subject withdrawal from the study will be recorded.

5 STUDY EVALUATIONS AND MEASUREMENTS (how measurements will be made)

See Table 1 in Appendix.

6 STATISTICAL CONSIDERATIONS

6.1 Statistical Methods

In Aim 1, we anticipate starting with a random selection of 600 providers from the list of eligible NC providers received from the NC Board of Medicine and NC Nursing Board, limiting to primary care providers identified as primary care through their provider type, which gives more than 90% power to detect a ten percentage point difference in the binary outcome, response to study recruitment. We will use binary models (logit, linear probability models) to examine response to recruitment as a function of study arm, controlling for provider type and county fixed effects.

For Aim 2, we will randomly recruit at least 60 enrollees (and up to 80 to enroll at least 20 providers per arm of this phase). The outcome to be monitored for Aim 2 is the number of ECHO sessions attended in the 6 months following randomization. Because this is a pilot study, the sample size is not powered for the primary outcome, number of ECHO clinics attended. We will conduct a negative binomial or other count data model (depending on statistical tests) of the number of sessions as a function of financial incentive arm to estimate the effect of financial incentives on participation.

7 STUDY INTERVENTION

See Table 2 in Appendix

8 STUDY INTERVENTION ADMINISTRATION

Phase 1 recruitment letters are designed in a 2 (prosocial mention of need for primary care providers trained in opioid use disorder treatment vs. none) x 2 (mention of additional financial supports available for participation in training vs. none). This yields 4 study conditions for recruitment letters:

1) Letter including prosocial messages and additional mention of practice supports available for participation,

2) Letter including prosocial messages but no additional mention of financial support available for participation,

3) Letter including an additional mention of financial support available for participation but no prosocial messages, and

4) Recruitment as usual letter that does not include prosocial messages or an additional mention of financial support available for participation.

Phase 2 examines participation in the learning community by group. Participants will be randomly assigned to 1 of 3 groups. The investigators are not disclosing the Phase 2 conditions until the end of the study, as approved by UNC's institutional review board (IRB).

At the end of data collection, we will send a debriefing form to all participants to share the information that we withheld from them at the beginning of the study.

9 SAFETY MANAGEMENT

There is no medical risk or risk of physical discomfort from this study. The risk to participants is minimal, and this does not meet the definition of a clinical trial, thus there is no data safety monitoring plan.

10 DATA COLLECTION AND MANAGEMENT

Procedures will be taken to minimize the possibility of a breach in confidentiality. No subjects will be identified in any publication or report of this study.

The nature of practice level data is ordinary, and unlikely to include socially stigmatizing conditions for providers. Secondary claims data will also be stored in secure databases. All working files are limited data sets, with patient names and contact information stripped off, but containing identified information on providers using a unique identifier (NPI) allowing linkage to data sources such as Medicaid prescribing information. This file will remain with the PI; the other research staff will access only files without patient names, addresses and other direct identifiers.

11 RECRUITMENT STRATEGY

PCPs will be identified from provider lists obtained through the NC Medical Board for physicians and physician assistants and the NC Board of Nursing for nurse practitioners. We will also use the DATA-2000 database of providers to help us identify PCPs who do not have waivers. Providers who are prescribing to Medicaid beneficiaries will be determined from NC Medicaid claims data, which is in use for the ECHO MAT study, and has been IRB approved for re-use for the ECHO Nudges study. We will use the list of providers currently participating in ECHO MAT, available to study investigators, to exclude the providers currently participating in ECHO (n=24). Once the denominator of eligible providers has been determined, the ECHO Nudges study team will randomly select providers in groups of 600 to randomize for pro-social or recruitment as usual invitations to participate in ECHO Nudges (and therefore ECHO MAT). From the group who decide to participate (outcome for Aim 1), we will re-randomize to one of the three arms of financial incentives. Effort to recruit providers for the Aim 2 analysis will follow immediately from the Aim 1 retention effort (e.g., providers must agree to participate in ECHO to be randomized to Aim 2). The number of sessions of participation within six months of engagement will be the Aim 2 outcome, thus no further efforts on retention will be utilized for the ECHO Nudges study.

12 CONSENT PROCESS

The project coordinator and/or the study team will give study information in both verbal and written form to each potential (provider) participant. Potential research participants are primary care providers in NC (MDs, DOs, NP, PAs). No patient identifying information will be collected through this effort. The consent form generated for enrolling PCPs by the investigators will be approved (along with the protocol) by UNC's IRB. Consent will be documented by the dated signature of the participant or the participant's legally authorized representative. The signature confirms that the consent is based on information that has been understood. Each participant's signed informed consent form will be kept on file by the investigators for possible inspection by regulatory authorities.

Since it is not possible to consent before recruitment to Aim 1, participants will complete the informed consent process at the beginning of Phase 2 of the study. The consent form will be shared with eligible participants when they contact the study team to enroll. Before enrolling in ECHO Nudges, participants will be asked to provide consent.

We will alter informed consent by only disclosing the study condition to which participants have been randomly assigned, and not the alternative Aim 2 treatment assignments, thus withholding the true purpose of the study, including the CT.gov #. This is because the aim of the second phase of the study is to test the hypothesis that compensating providers for time spent in MAT training increases the time they spend training. If we disclose that participants are randomly assigned to receive study incentives or not, and different amounts. That knowledge alone could lead to differential involvement in the study, which would make it impossible to test the hypothesis.

13 PLANS FOR PUBLICATION

We will disseminate our findings by systematically distributing information through multiple channels and users. We will ensure that it is oriented to the needs of users; utilizes diverse dissemination methods with written, oral and electronic media; and maximizes existing and new relationships, thus informing all networks about research study results. Our previous policy work in behavioral health policy has been successfully disseminated in regional, national, and international settings. Our research project meetings will include a quarterly dissemination discussion in which we will consider stakeholder user needs, emerging project and research findings, and places where stronger relationships and linkages are needed.

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APPENDIX

Table 1: Study Evaluations and Measurements

Type	Name	Time Frame	Brief Description
Primary	Number of recruited providers that contact staff for information about enrolling in the study	From start of recruitment to end of data collection for last participant, up to 1.5 years	Phase 1 recruitment interventions will be compared based on the number of recruited providers that reach out to study staff via email, phone, or any other method.
Secondary	Number of recruited providers that complete enrollment in the study	From start of recruitment to enrollment fulfillment, up to 1 year	Phase 1 recruitment interventions will be compared based on the number of recruited providers that enroll in the study.
Primary	Number of UNC ECHO clinic sessions a participant attends	Study follow up period (from enrollment to 6 months after enrollment; for participants who had not completed as of 3/9/2020 the 6 months was extended by 3 months due to decreased ECHO clinic sessions because of COVID-19)	Phase 2 study interventions will be compared based on the number of UNC ECHO clinic sessions that a participant attends.
Secondary	Total amount of time a participant attends a UNC ECHO clinic session	Study follow up period (from enrollment to 6 months after enrollment; for participants who had not completed as of 3/9/2020 the 6 months was extended by 3 months due to decreased ECHO clinic sessions because of COVID-19)	Phase 2 study interventions will be compared based on the total amount of time that a participant attends a UNC ECHO clinic session (P2)
Secondary	Number of participants that receive a DATA 2000 waiver	Study follow up period (from enrollment to 6 months after enrollment; for participants who had not completed as of 3/9/2020 the 6 months was extended by 3 months due to decreased ECHO clinic sessions because of COVID-19)	Phase 2 study interventions will be compared based on the number of participants that receive a DATA 2000 waiver. MAT waiver training is an 8-hour course for physicians and a 24 hour course for advanced practitioners that is required for providers to prescribe and dispense MAT.
Secondary	Number of participants that begin prescribing MAT paid by Medicaid	Study follow up period (from enrollment to 6 months after enrollment; for participants who had not completed as of 3/9/2020 the 6 months was extended by 3 months due to decreased ECHO clinic sessions because of COVID-19)	Phase 2 study interventions will be compared based on the number of participants that begin prescribing MAT.

Table 2: Interventions for Aim 1

Type	Name	Description
Behavioral (e.g., Psychotherapy, Lifestyle Counseling)	Phase 1 Condition 1	Providers assigned to this condition will be sent recruitment materials that are 'recruitment as usual' (Phase 1 Condition 1). These materials will not include prosocial messaging and will not include an additional mention of financial support available for participation.
Behavioral (e.g., Psychotherapy, Lifestyle Counseling)	Phase 1 Condition 2	Providers assigned to this condition will be sent recruitment materials that include an additional mention of financial support available for participation but will not include prosocial messaging (Phase 1 Condition 2).
Behavioral (e.g., Psychotherapy, Lifestyle Counseling)	Phase 1 Condition 3	Providers assigned to this condition will be sent recruitment materials that include prosocial messaging, but do not include an additional mention of financial support available for participation (Phase 1 Condition 3).
Behavioral (e.g., Psychotherapy, Lifestyle Counseling)	Phase 1 Condition 4	Providers assigned to this condition will be sent recruitment materials that include prosocial messaging and an additional mention of financial support available for participation (Phase 1 Condition 4).
Behavioral (e.g., Psychotherapy, Lifestyle Counseling)	Phase 2 Condition 1	Providers who enroll in the study and are assigned to this condition will be in this group. The investigators are not disclosing the phase 2 conditions until the end of the study.
Behavioral (e.g., Psychotherapy, Lifestyle Counseling)	Phase 2 Condition 2	Providers who enroll in the study and are assigned to this condition will be in this group. The investigators are not disclosing the phase 2 conditions until the end of the study.
Behavioral (e.g., Psychotherapy, Lifestyle Counseling)	Phase 2 Condition 3	Providers who enroll in the study and are assigned to this condition will be in this group. The investigators are not disclosing the phase 2 conditions until the end of the study.