This document presents the MOTIVATOR© program logic model, section 1 of 8, dated to October 2023. For full materials, please contact the corresponding author.

Slide	Min	Content	Teaching method / Materials	Comp taught	Comp used	Short term aims (immediate)	Long term aims (in practice)	Impact on patient
1		**Title page**		/	/			
	40	**The challenge of behaviour change - A**						
		Introduction						
2,3,4	4	Welcome slide & disclosure of conflict of interest	Introduce yourself and ask participants to introduce themselves (name and medical specialty). (Very quick)	/	/	/	/	/
5	1	Presentation of program outline	Outline is included in activity sheets. If facilitator is bilingual, this can be a good moment to mention that francophone participants are welcome to formulate their comments/questions/participation to activities in French.	/	/	Describe what one can expect from the training	/	/
6	1	Present objectives for the training program	Objectives are included in activity sheets					
7	1	Focus on the role of doctors who often need to address health behaviours and chronic disease, patient adherence	Direct/Lecture			Present the main issue addressed by this training: adherence to behaviour	Place the training (and MC) as part of the solution	/
		Icebreaker						
8	10	Identity own frustrations with patient health behaviour changes: What frustrates you about your efforts to change patient behaviour? Do you have a specific example in mind? What did you do? What would others in the group have done in your situation? What example of a successful behaviour change consultation do you have? Discussion with the group.	Participants will split in small groups (4) for around 5 minutes to discuss the questions on the slide. Remind participants to try to think of instances where a specific behaviour needed to be changed on the part of the patient. *Note: with a group of up to 10 participants, there is no need to form break-out groups - acitivities can be done within the large group	/	EMP, LIS, JDG, ACC, GOAL, COLL.	Engage in training by tying into own experience and expressing frustrations, while recognizing their successes.		

				/				
9	2	Identifiy own objectives for this training	Highlight that this training they are already doing many things that work with many patients, but that this training will teach new tools that can be useful in interactions with patients who react differently.Then prompt the questions that will inform their individual objectives: What would it mean if you could improve these interactions? By the end of these four hours, what do you wish to be able to accomplish? Ask participants to take the time to jot down their answers to the group discussion questions in their activity booklet.	/	EVO, GOAL	Recognize how this training could benefit their clinical practice.	Improved integration of skills through connection with own experience and professional needs	/
10, 11		Presenting part 1: The challenge of behaviour change		/	/			
		Traditional approaches to behaviour change						
12	3	Q: What is typically done to get a patient to change?	Ellicit answers from participants	COLL	LIS, COLL, INF	Identify own strategies and prepare participant to link it with "advice-giving" strategies described next	Change the identified instances of advice-giving in practice	Improved alliance through feeling listened to, and improved engagement through collaboration in treatment plan

13	1	"Advice-giving"	Describe use of advice-giving in clinical practice, and highlight its short-comings: underestimating pt knowledge, ineffective in many cases	COLL	N-JUDG	Identify shortcomings of advice-giving (by explaining)	"	"
14	1	The urge to offer advice is normal, so is the urge to ignore is	thought experiment - answer in your head/ After exercise: highlight: it is so tempting to give advice, but we know it doesn't really stick.	RES	INF, EVO	Normalize the instinct of advice-giving, and recognize its shortcomings in real life (by showing)	"	"
15	3	Q: What does it mean to provide patient-centered care in practice?	Elicit responses. Additional info if pertinent: put forth increasingly in the past 30 years, associated with increase in pt-satisfaction, self-management; may mediate higher adherence and well-being, some associations to better health outcomes (blood pressure, pain) (ref: 18-20	/		Highlight that patient-centered care can mean different things to different people and that implementing it can be hard		
16	1	Expert role & Patient-centred care	Direct/Lecture: Physicians are expected to reconcile their “expert role” with roles associated with patient-centred care, but withut an operational definition, and without appropriate training. There is tension between the different roles they are expected to fill	EMP	EMP, ACC, N-JUDG, HOS	Recognize discrepancy/tension between patient-centred care in theory and practice. Normalize the difficulty of using patient-centred care with little training, and "expert role" taking the majority of the space.	Decrease resistance to patient-centered care by feeling better equipped to do it. Use MC to put	Improved

17	1	Reality of healthcare context	Direct/Lecture	EMP	COLL, INF, EVO	Highlight that trying to do something (patient-centered care) when not in right environment & without proper guidance is frustrating and can create resistance - just like our patients feel.	patient-centred care in practice	alliance
18	1	The patient's perspective:"exercise more" thought experiment	Direct/Lecture: Highlight that we all are ambivalent about changing our own behaviours, even when we know what we should do. The discrepancy between the end goal (being in better shape) and the process (painful, frustrating, time-consuming exercise) creates ambivalence	EMP		Ellicit better understand of our resistance to change + ellicit *empathy* by illustrating that *we* are resistant to change		
		Adherence & Readiness						
19	1	The knowledge-behaviour gap: it's not that patient's don't know what to do, it's that they don't do what they know	Direct/Lecture: Our job is to help them see the disconnect between their current behaviour and their goals (challenge = people want to be well but not change) No need to convince that the behaviour is good, convince them to do it. **Acknowledge verbally in this slide or the next - it's not all or nothing**		INF, COLL	Gain common vocabulary for rest of training: Knowledge-behaviour gap	Change perception of « resistance ». Integrate empathy for reasons for "resistance".	

20	1	2 things to know: what behaviour to target, are they ready	We think we know what they should be working on We don't know the behaviours they are already engaging in, the ones they hate, they like, etc.		COLL	knowledge-behaviour gap & Stages of changes		Receive an intervention well-matched to needs
21-22	2	Readiness and stages of change	Direct/Lecture. Mention that this is not an exact science, but that being in the right ballpark is enough.	ACC, RES				
23-24	4	"Are they ready" part 1	« Are they ready » exercise: Participants are shown a short participation statement, and asked if participants are ready and at what change they stand. (2 cases, 1 in pre-contemplation, 1 in preparation). Use the poll function to go through each case. *In small groups, no need for the poll function. "Ready or not" is also not an exact science. Does your instinct tell you this person is engaged and ready to collaborate to their care?	LIS, COLL, ACC	COLL, INF	Verify understanding and consolidate new knowledge	Adopt Stage of change approach in practice	
		Motivational Communication						
25-26	2	Introduction to Motivational Communication + core competencies	Direct/Lecture. Definition of MC and LEARN tHE BASICs competencies are in activity sheets. This is the language we use to motivate people to enact the change. Describe competencies of 1) what to do, 2) how to be, 3) what not to do	/	/	First look at what MC entails	Use of LEARN THE BASICS mnemonic to integrate MC	/