Behaviour Change Counselling Development Program (BCCDP) in Primary Health Care

Evaluation of Program Implementation

Primary Health Care & Chronic Disease Management Network

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Contents

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Executive Summary

Consider the following:

- *Health advancements in the 19th century were due to significant advances in hygiene.*
- *Health advancements in the 20th century were largely associated with advancements in medicine.*
- *Advancements in the 21st century are based on health behaviour change.*

Now is the time for our health systems to focus on the enabling factors that will support citizens to reach their full health potential and realize their value and importance as a key member of the health care team. Health systems that ground care approaches in self-management (SM) offer higher quality care, have reduced health system usage, improved health outcomes, and better levels of provider and patient satisfaction[2,3,4].

Behaviour change counselling (BCC) is an essential skillset that all health care providers (HCPs) should have and use as a method of self-management support (SMS). However, the literature suggests that SMS is not routinely a part of health care in Canada. In fact, it has been shown that HCPs only engage in SM conversations 50% of the time, and far fewer refer their patients to eligible SM resources or programs[6,7].

The ***Primary Health Care Behaviour Change Counselling Development Program (PHC BCCDP)*** was developed and implemented for PHC providers across Nova Scotia, to provide a practical and impactful practice support program that allows providers to build their knowledge, skills, and competencies in BCC in a flexible, multi-modal way, that meets their needs based on their interest and readiness to learn, providing opportunities to practice and incorporate skills into practice.

A multi-methods evaluation of the program was conducted between the fall of 2020 to 2022. This included pre and post surveys of e-modules and virtual workshops, a provincial staff survey, and leadership interviews. The objectives of the evaluation were to:

1. Examine whether more participation in training and practice opportunities have an impact on application of skills to practice.
2. Examine whether levels of capability, opportunity, and motivation (i.e., COM-B model of behaviour components) have an impact on implementation of skills in practice.
3. Determine the enablers and barriers of successful integration of skills.

What did we find?

- Individuals who participated in the program had higher levels of perceived competency and confidence in applying skills to practice.
- Most participants felt satisfied or very satisfied with the care they provided because of participating in the program.
- The format of the BCCDP was viewed to be useful and practical, especially the variation in program offerings.
- Participants showed improvements in knowledge after participating in the e-modules, and those who participated in the virtual workshops felt it was time well-spent in increasing their competency.

- Family practice nurses and chronic disease teams had the highest rates of participation in the program.
- Time to participate in training and practicing the skills was noted several times throughout the evaluation as a significant enabler to knowledge and skill building.
- Most participants felt that modules 1-4 (Foundations of Behaviour Change) should be required for leaders and HCPs in PHC to complete.
- In the Eastern Zone it was shown that leaders who visibly endorsed the program, embedded BCC skills into their own practice (i.e., through their leadership team meetings, conversations), and expected staff to participate in the BCCDP had higher e-module completion rates than any other zone.
- A frequently cited enabler was leadership support, which substantiates what is already known about BCC practice integration.

What are the key recommendations?

Leadership support

- All levels of leaders in PHC should complete e-modules 1-4 every two years to gain an understanding of the concepts and skills, so they can encourage HCPs to participate in the training opportunities and consider ways to embed into their leadership practice. Efforts to attend virtual workshops should also be prioritized, when possible.
- A BCCDP workshop developed specifically for leadership should be developed and implemented.

Training and professional development

- Maintain the current training structure. All HCPs in PHC should complete e-modules 1-4 every two years. E-modules 1-4 should be optional for administrative staff.
- Have HCPs with interest and higher perceived levels of competency deliver components of the BCCDP.
- Host an in-person staff education day to promote BCC knowledge and skills.

Resources

- Build-in dedicated time for HCPs to complete training and opportunities to practice the skills.

Integration into Workflows

- Develop an EMR documentation template.
- Communicate ways that BCC skills can save clinical time.

Culture and Readiness

- Promote a culture of SMS, including:
    - Promoting and incorporating BCC knowledge and skills as core competencies for all HCPs in PHC. For example, integrating competencies into learning assessments, orientation, team agreements, and performance appraisals.
    - Leaders promoting and communicating the value and importance of this skillset.
    - Integration of behaviour change principles into workflows, assessment forms, programming, patient materials etc.
    - Support for leaders and HCPs to attend training and practice skills.

Monitoring and Evaluation

- Develop a tool to measure and monitor HCP competency in BCC.
- Streamline the BCC evaluation framework, including streamlining and pairing down evaluation tools.
- Consider opportunities for patient-focused evaluation of the BCCDP.

Community of Practice

- Create a community of practice that allows HCPs to meet virtually to practice, discuss, troubleshoot, and share resources.
- Incorporate zone-based peer-champions, with dedicated time to building capacity in BCC across the zone. For example, a 1.0 FTE role per zone, with 0.5 FTE focus on behaviour change support and 0.5 FTE to deliver wellness programs. These champions would be supported by the BCCDP lead, as part of a team. They would also participate in the development and delivery of training and program resources, as well as a community of practice.

Supervision and Monitoring

- Develop a competency program for BCC champions. Look to the work done for motivational interviewing.

Moving Forward

The results of this evaluation add to the literature base on SMS and behaviour change. It was shown that a system-level BCCDP can be implemented effectively into PHC by using multi-modal, resource-efficient methods to deliver programming and build competency across the province. Opportunities exist to strengthen the program to support leaders and HCPs to enhance the use of this important skillset. Critical enablers include leadership support, time to participate in training and practice skills, and a collective shift towards a culture of SMS. In this way, BCC skills will not be seen as an “add-on” to clinical practice, but rather the foundation for which all of health care is built upon.

Foreword

Nova Scotia's *Action for Health: A Strategic Plan* charts a course for a healthier Nova Scotia by laying out a multi-year strategic plan to transform health care over the next four years. Wellness and chronic disease prevention and management are key areas of focus through several of the solutions. Primary Health Care (PHC) plays a key role in the delivery of chronic disease and wellness promotion services across the province. Helping to support and engage Nova Scotians to live well and be the driver of their own health and wellness is a key aspect of this. Nova Scotians need the skills, supports, and confidence to understand and manage their health and be actively involved in making key decisions and actions about their care. Self-management (SM) and self-management supports (SMS) are integral components of high-quality person-centered care. A multi-faceted approach to SMS within PHC and other areas of the health system is required to support individuals, their families, and caregivers to live well, and to prevent, and respond to the impact of chronic disease.

The *Primary Health Care Behaviour Change Counselling Development Program (PHC BCCDP)* is the result of many years of dedicated collaboration and work to develop a practical and impactful practice support program that enables PHC providers to build competency and confidence in behaviour change counselling, a key aspect of SMS. This report will document the key aspects of the provincial approach to program development, implementation, and evaluation to share successes, opportunities for improvement, and ultimately to inform future iterations of the program. The findings may be useful and applicable to other jurisdictions who are supporting SM.

Introduction

Behaviour change counselling is an essential skillset that Primary Health Care (PHC) providers use in supporting patients to improve their health. The *PHC Behaviour Change Counselling Development Program* (BCCDP) supports PHC providers to build their knowledge, skills, and confidence to work collaboratively with patients to elicit health behaviour change. There are various components and enablers of the program, including training (e-modules, virtual workshops, coaching), leadership support, mentorship, and monitoring and evaluation. The first phase of implementation included the launch of e-modules and virtual workshops for PHC team members and formal leaders across the province.

An evaluation framework, developed through a theory of change process, identifies key evaluation questions and indicators. These indicators inform the collection of data to support the systematic evaluation of the program over time. The COM-B model, (Capability, Opportunity, Motivation-Behaviour)[17] provides a framework for understanding behaviour as well as barriers and facilitators to behaviour change within this evaluation framework. Pre and post surveys were used to collect data from e-modules and virtual workshops. Semi-structured leadership interviews and a PHC-wide staff survey were conducted to better understand the barriers, enablers, and program impacts.

Background and Context

Nova Scotia has some of the highest rates of chronic disease in Canada. The development of chronic conditions is attributable to a range of factors, including the impact of the social determinants of health (i.e., income, geography, education, culture) as well as common modifiable risk factors and health behaviours such as inactivity, unhealthy eating, smoking, alcohol use, and stress[1]. The risk of death, diabetes, myocardial infarction, and stroke can be dramatically lowered in those who practice health behaviours such as healthy eating, regular physical activity, and avoiding smoking [2, 3, 4].

Many high quality randomized controlled trials have shown that Health Care Providers (HCPs) play a crucial role in supporting their patients to make and sustain health behaviour changes to improve health outcomes[5]. Despite the ample evidence of positive outcomes, SMS is not consistently a routine part of health care for all Canadians with chronic conditions. Studies suggest that PHC providers only engage in SM discussions with their clients 50% of the time and far fewer (25%) of eligible clients are referred to specific SM groups or classes[6,7]. Lack of awareness of the benefits of SMS, lack of training and professional development opportunities, and lack of time are some of the barriers HCPs may experience in using a SMS approach[8].

Evidence suggests that HCPs need to acquire skills in three main areas to effectively deliver SMS[9,10,11,12]:

- **Behavioural Change** (i.e., competencies in psychosocial techniques such as goal setting, assessing readiness to change, motivation and self-efficacy).

- Person-Centered Approach (i.e., skills in communication such as establishing an empathic relationship, joint decision making, and putting the preferences and priorities of the client at the center of care planning).
- Contextual factors (i.e., ability to support specific populations, flexibility to tailor interventions to people's unique needs, including the impact of the social determinants of health).

Capacity building approaches for HCPs in SMS should be evidence-based and grounded in behaviour change theory (i.e., Transtheoretical Model of Change, Cognitive Behavioural Therapy). The best training/practice support model depends on a range of factors, including health care provider role, their readiness to participate, context (i.e., practice area, patient population), and resources available to support and sustain these skills[13].

Purpose

The BCCDP is built on the curriculum developed by the Behaviour Change Institute (BCI), PHC, Nova Scotia Health, which is grounded in behaviour change theory, can be applied by any health care provider in any setting, and does not require extensive training and certification to apply in practice[14, 15]. Historically, a select group of providers had access to the training opportunities and resources available from the BCI. Training, resources, and continued opportunities for behaviour change counselling skill development are now provided to all within the Nova Scotia Health system. E-modules provide education and awareness of behaviour change counselling to a large audience of HCPs, while the virtual workshops provide an opportunity to practice and develop skills in smaller groups for those who are keen to learn more. Using a virtual platform allows the reach and impact to be as large or small as desired, without requiring additional effort.

This evaluation aims to understand how a system-level program impacts the uptake and use of skills by PHC providers, by examining the:

- influences of capability, opportunity, and motivation (COM-B model of behaviour[17]) to PHC HCP practice change.
- enablers and barriers to competency development for HCPs.
- perceived impact of the program on HCP practice satisfaction.
- perceived impact of the program on patients, as reported by HCPs.

Objectives

The evaluation objectives were to:

1. Examine whether more participation in training and practice opportunities have an impact on application of skills to practice.

2. Examine whether levels of capability, opportunity, and motivation (i.e., COM-B model of behaviour components) have an impact on implementation of skills in practice.

3. Determine the enablers and barriers of successful integration of skills.

Program Description

The BCCDP has three stages, each of which builds on the knowledge and skill competencies from the previous stage (Appendix A):

- Stage 1: Foundations of Behaviour Change – HCPs have the skills to work collaboratively with individuals to motivate them to consider making health behaviour changes.
- Stage 2: Building on Behaviour Change – HCPs can support individuals as they change their behaviour and facilitate long term changes.
- Stage 3: Comprehensive Approach to Behaviour Change – HCPs can acknowledge and support individuals dealing with psychosocial concerns to make lasting behavioural changes.

The word "development" is critical because it assumes that HCPs will want and need different levels of training depending on their professional background, practice setting, and readiness to integrate skills into practice. As such, some HCPs may only receive one "stage" of training, while others may complete all three stages. PDSA (plan, do, study, act) cycles of learning and application of knowledge will be integral to competency development. Each stage of the program builds on the previous and is required before progressing to the next stage.

Program enablers include:

- Leadership support – Formal leaders participate in training opportunities and support HCPs to partake in training and other activities to develop their behaviour change knowledge (i.e., allow opportunities to practice skills). They understand the long-term commitment that is required to realize a paradigm shift in care delivery and support sustainability.

- Training and professional development – The program provides a range of formal opportunities for HCPs to participate in training, based on their readiness. The program supports formal leaders and HCPs to further develop knowledge and skills and integrate into practice.

- Resources – Direct and indirect resources (i.e., human, financial, time, space, and materials) are aligned to enable the uptake of behaviour change knowledge and skills and the use of behaviour change interventions.

- Integration into work-flows - Behaviour change approaches must be integrated within the existing flow of work (i.e., patient assessments, integration into group programming, forms, meetings) to support behaviour change and ensure sustainability.

- Culture and readiness - Celebrated and embraced, behaviour change is embedded in our culture as evidenced in the day-to-today work offered by program and service areas. Behaviour change is integrated into the vision and principles of program and service areas and is implemented into operational frameworks.

- Monitoring and evaluation - Monitoring and evaluation is an essential enabler to identify both HCP and patient success. For HCPs, monitoring training, uptake of skills, translation to practice and understanding challenges/barriers to implementation is required. A core set of indicators has been developed to assess provider knowledge, skills, readiness, confidence, satisfaction, and practice change. Over time, relevant program/service area specific indicators may also be identified.

- Community of Practice- Behaviour change peer leaders are HCPs who work collaboratively with formal leaders (manager and/or team lead) and the BCCDP team to translate behaviour change counselling knowledge and skills into everyday practice. Over time, a community of practice of peer leaders will be implemented to:
    - Advance the uptake of required knowledge and skills in clinical practice.
    - Support cross-learning that spans the continuum of care, disciplines of care, and program/service areas.
    - Create a shared repertoire of resources (experiences, stories, tools, materials, and ways of addressing recurring barriers/problems).
    - Share knowledge, skills and learnings with colleagues, teams, and leaders.

- Supervision and mentorship - Supervision and mentorship is required for peer leaders and trained HCPs. Supervision and mentorship build HCP confidence to apply the skills, supports the sustainability of the program, and ultimately leads to competency attainment. Peer leaders receive supervision and mentorship from the program team in the form of a community of practice. Newly trained HCPs will receive initial supervision and mentorship from the BCCDP team but over time, mentorship and supervision is ultimately assumed by peer leaders.

The training program includes:

1) Self-directed e-modules – completion of e-modules is a pre-requisite for the further training opportunities. E-modules were the first component of the program to be launched, accessed through the Learning Management System (LMS) of Nova Scotia Health (NSH)/IWK. Stage 1 was implemented in October 2020, stage 2 mid-November 2020, and stage 3 the end of November 2020. Foundations of Behaviour Change (Stage 1) includes four e-modules; Building on Behaviour Change (Stage 2) includes two e-modules, and Comprehensive Approach to Behaviour Change (Stage 3) includes two e-modules. Each e-module takes between 45- 60 minutes to complete. PHC staff were strongly encouraged to complete all e-modules, with a strong focus on the completion of stage 1, Foundations of Behaviour Change.

2) Virtual workshops – regular opportunities for HCPs to practice skills together, specific to each stage of the program. Each month a different skill was featured for a total of 12 workshops. PHC staff were strongly encouraged to attend these sessions. Virtual workshops were launched in January 2021.

3) Virtual coaching - opportunities for tailored coaching were made available for leaders, providers and teams that had started on their behaviour change counselling journey to help support integration of skills into practice.

Evaluation Sample

HCPs (i.e., nurse practitioners, nurses, allied health) and formal leaders from the PHC NSH system were invited to participate in the program beginning in October 2020. Participation was not required but was strongly encouraged by leadership. A total of 938 people were eligible to complete the program.

Evaluation Framework

The BCCDP falls under component two of the PHC SMS Framework: *Informed and Skilled Health Care Providers*. The framework and conceptual model were developed by a task group of formal leaders, HCPs, and patient family advisors in 2019. The evaluation framework (Appendix D) was developed using a theory of change. One of the overarching outcomes was that *Health care providers (HCP's) will have increased knowledge, skills, and confidence to incorporate a self-management support (SMS) person-centered approach.* The BCCDP is an initiative to address this goal. The evaluation framework determined key evaluation questions and indicators. Pre and post surveys for e-modules and virtual workshops, which mapped to key indicators from the evaluation framework, were developed for each stage of the program. HCPs were strongly encouraged to complete surveys as they participated in these aspects of the program. A leadership interview guide and staff survey were developed to evaluate program impacts, facilitators, and barriers.

The COM-B Model of behaviour (Capability, Opportunity, Motivation, and Behaviour) is the theoretical framework used to inform indicators related to behaviour change[16,17]. Indicators measuring providers' knowledge and skills map to stage-based competencies (Appendix F). Indicators relating to readiness to change were informed by the Prosci ADKAR® Model[18, 19], which includes the following components: Awareness of the need for change, Desire to participate in and support the change, Knowledge on how to change, Ability to implement the required skills and behaviours and Reinforcement to sustain the change (Prosci, n.d.).

Data Collection and Analysis

Methods

Quantitative Evaluation

E-module and virtual workshop surveys were created in Select Survey and data were extracted to a dashboard (created in excel and saved in a password protected NSH shared drive), which served as a platform to display data collected throughout the program implementation (i.e., October 2020-October 2022). During this period, the dashboard data was used to monitor progress towards the evaluation indicators, inform continuous program development, and was shared with PHC leadership and staff.

Evaluation Cohort

E-modules:

The maximum cohort includes 473 people who completed the Stage 1 pre-test survey. Completion of the pre-test survey is required to progress through the modules in each stage. Completion of the post-test is required to progress to the next stage. There was attrition at each stage, with 78 people (16%) remaining to complete the Stage 3 post-test survey.

Virtual Workshops:

As of Oct 2022, 209 surveys were completed across 12 virtual workshops. Individual participants could complete one workshop or all 12. Completion of previous workshops was not required to participate in a specific workshop. The number of surveys completed for each workshop are as follows:

1. Ask, Listen, Summarize, Invite: 63 surveys
2. Non-judgmental Curiosity: 40 surveys
3. Motivational Argument, Ambivalence, Rolling with Resistance: 27 surveys
4. Defining Behaviour: 20 surveys
5. Readiness Assessment: 9 surveys
6. Working with Green Lights – Goal Setting: 10 surveys
7. Working with Yellow Lights: 15 surveys
8. Working with Red Lights: 7 surveys
9. Sustaining the Change – Shaping, Reinforcement Management and Stimulus Control: 7 surveys
10. Distress/Well-being Assessment: 7 surveys
11. The 4S's: 1 survey
12. Replacing the Function – Stress Reduction: 3 surveys

Statistical Analysis

Descriptive statistics were computed to describe the evaluation cohort. Frequencies and percentages were calculated for categorical variables and compared using chi-square or Fisher's Exact as appropriate.

E-modules:

Readiness was assessed though the pre-test survey using a 5-point Likert scale (1= strongly disagree, 5 = strongly agree) for each of 7 statements. Unless stated otherwise, “agree” and “strongly agree” were combined and reported as “agree” and “disagree” and “strongly disagree” were combined and reported as “disagree.”

Satisfaction was assessed though the post-test survey using a 5-point Likert scale (1= strongly disagree, 5 = strongly agree) for each of 6 statements. Unless stated otherwise, “agree” and “strongly agree” were combined and reported as “agree” and “disagree” and “strongly disagree” were combined and reported as “disagree.”

Confidence in using behaviour change counselling skills in practice was assessed though the post-test survey using a 4-point Likert scale (1= not at all confident, 4 = very confident) for each of 14 statements tailored to the content of the respective e-module. Unless stated otherwise, “very confident” and “somewhat confident” were combined and reported as “confident” and “not very confident” and “not at all confident” were combined and reported as “not confident.”

Having the opportunity and a plan to integrate behavioural change counselling into practice were assessed though the post-test survey using a binary scale (yes/no) for each of 2 statements. If respondents answered no to the opportunity question, they explained the reason in an open-ended question. Regardless of the response to the planning question, respondents were asked to explain the reason in an open-ended question.

Competency was assessed through the pre- and post-test survey using a series of multiple-choice questions tailored to the content of the respective stages. For a given stage, the pre- and post-test questions were the same. Due to privacy concerns, no personal identifiers (i.e., name, employee ID) were collected through the surveys, meaning the pre- and post-test results could not be matched at an individual level. As such, both the number and percentage of respondents with a passing grade (50% or higher) are presented in this report.

Stage 1: 14 questions

Stage 2: 23 questions

Stage 3: 14 questions

Virtual Workshops:

Satisfaction was assessed though the post-workshop survey using a 5-point Likert scale (1= strongly disagree, 5 = strongly agree) for each of 5 statements. Unless stated otherwise, “agree” and “strongly agree” were combined and reported as “agree” and “disagree” and “strongly disagree” were combined and reported as “disagree.”

Use of BCCDP skills in practice was assessed though the post-workshop survey using a 4-point Likert scale (1= never, 4 = always) for a series of 2 to 5 statements tailored to the content of the respective workshop. Unless stated otherwise, “most of the time” and “always” were combined and reported as “most or all of the time.” Responses are presented for virtual workshops with 30 or more post-workshop surveys completed.

Confidence in using BCCDP skills in practice was assessed though the post-workshop survey using a 4-point Likert scale (1= not very confident, 4 = very confident) for a series of 2 to 5 statements tailored to the content of the respective workshop. Unless stated otherwise, “very confident” ‘confident’ and “somewhat confident” were combined and reported as “confident.” Responses are presented for virtual workshops with 30 or more post-workshop surveys completed.

Evaluation

A staff survey, created in Smartsheet, was administered to all PHC staff in October 2022 for a period of two weeks. The survey was a combination of quantitative questions (5-point Likert scale) and open text questions. Additionally, nine interviews were conducted with NSH PHC leadership. Both the survey and interview questions were based on the evaluation framework and were set to elicit responses to components of the COM-B model: Capability, Opportunity, Motivation, and Behaviour of the participants and leadership (see Appendix C and D for more information).

Dissemination of Results

This project has been approved as a quality improvement initiative for the purposes of ensuring quality, evaluation, or standards of care within a quality review program under the oversight of the PHC Interdisciplinary Quality Improvement & Safety Council, NSH. Results will be shared with key stakeholders internal and external to NSH, as appropriate. Opportunities to formally publish program results will be explored.

Results

Quantitative Analysis

E-module and Virtual Workshop Completion Rates

E-Modules

A total of 938 people were eligible to complete the e-modules and virtual workshops. Table 1 shows that more people completed e-modules in Foundations of Behaviour Change, compared to Building on Behaviour Change and Comprehensive Approach to Behaviour Change.

Table 2 shows completion rates for virtual workshops, of which Non-Judgmental Curiosity had the most participants, while The 4 S's and Replacing the Function – Stress Management, had the least number of participants. This is not surprising given that the Foundations workshops were offered more times and were highly recommended compared to the Building and Comprehensive workshops.

Table 1: E-Module Completion Rates in PHC

E-Module	Participants eligible to complete e-module (n)	Completion rate for eligible participants	
		n	%
Foundations M1	938	323	34.4%
Foundations M2	323	298	92.3%
Foundations M3	298	281	94.3%
Foundations M4	281	259	92.2%
Building M1	259	171	66.0%
Building M2	171	134	78.4%
Comprehensive M1	134	107	79.9%
Comprehensive M2	107	96	89.7%

Virtual Workshops

Table 2: Virtual Workshop Completion Numbers in PHC (n=938)

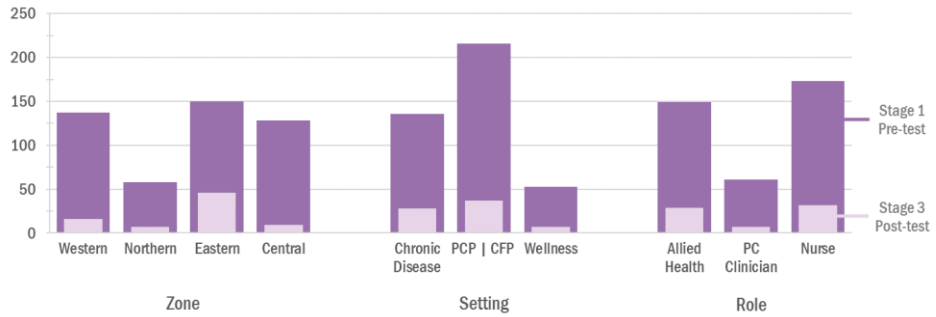
Virtual Workshop Name	Total number of sessions offered (#)	Total number of participants (#)
Ask, Listen, Summarize, Invite	3	61
Non-Judgmental Curiosity	3	78
Motivational Argument, Ambivalence, Rolling with Resistance	3	61
Defining Behaviour	3	46
Readiness Assessment	2	18
Working with Green Lights	3	33
Working with Yellow Lights	4	31
Working with Red Lights	2	22
Sustaining the Change	2	10
Distress/Well-Being Assessment	2	15
The 4 S's	1	5
Replacing the Function – Stress Reduction	2	5

E-Module Survey Participation and Retention

Completion of surveys was optional for participants who completed the e-modules and virtual workshops. For those who completed the e-module surveys, retention to the end of Stage 3 was highest for Eastern Zone at 31% compared to 12% in Northern and Western Zone and 7% in Central Zone. When examined by practice setting, Chronic Disease Teams had the highest retention (21%) compared to PCP/CFP teams and Wellness teams (17% and 13% respectively). When examined by job title, allied health professions and nursing staff had the highest retention (19 & 18% respectively) compared to primary care clinicians (11%).

Retention was highest for Eastern Zone, chronic disease teams, allied health professions and nurses

Figure 2: Number of survey respondents at the beginning and end of the BCCDP by zone, setting, and profession

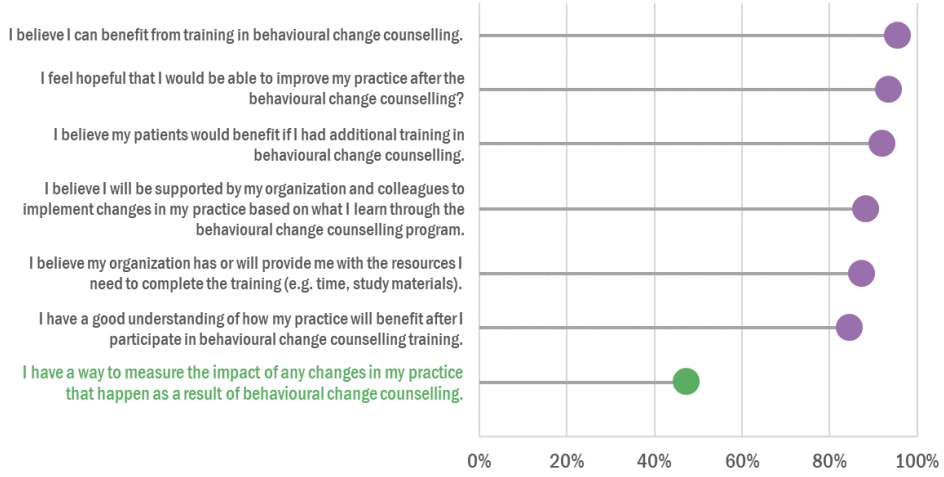


HCP Readiness for Behaviour Change Counselling

Most survey respondents (85%-96%) indicated that they agreed with 6 of the 7 readiness statements. However, less than half of survey respondents (47%) agreed that they had a way to measure the impact of any changes in their practice that happened as a result of behavioural change counselling.

Respondents were ready to benefit from the BCCDP, but they lacked a way to measure the resulting change in their practice

Figure 3: Percentage of respondents who agreed with 7 readiness statements



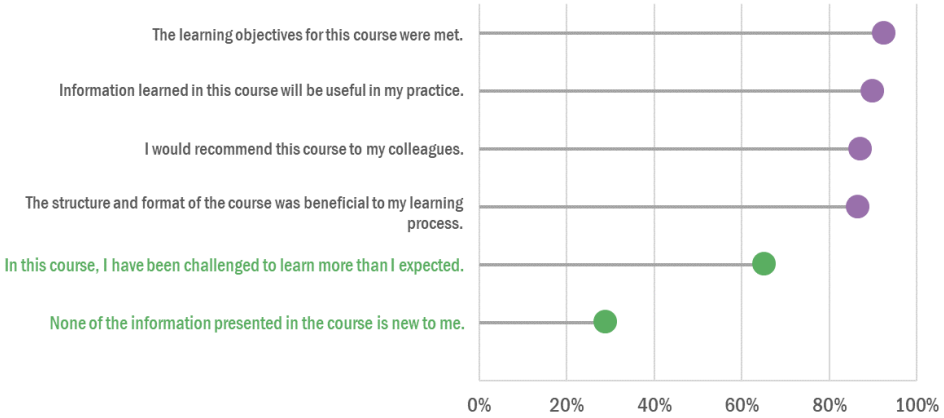
Satisfaction with BCCDP E-Modules

Most survey respondents (86%-92%) indicated that they agreed with 4 of the 6 satisfaction statements. Fewer survey respondents (65%) agreed that they had been challenged to learn more than expected

Even fewer survey respondents (29%) agreed that there was no new information presented in the course, meaning most respondents were exposed to at least some new information.

Most respondents were satisfied with the BCCDP even though many were not challenged as much as expected, and some were familiar with the content (I.e., none was new)

Figure 4: Percentage of respondents who agreed with 6 satisfaction statements

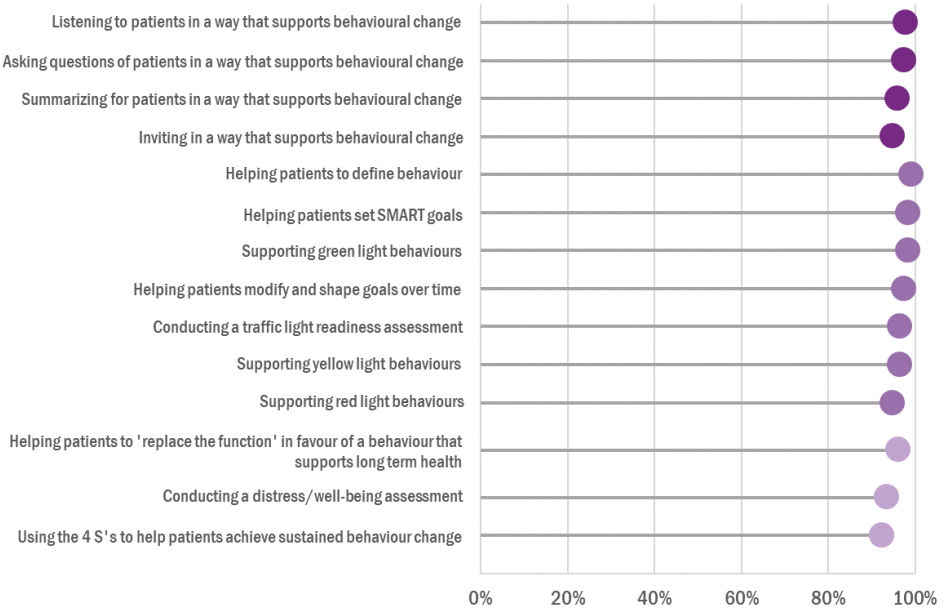


Confidence Using BCCDP Skills

Most survey respondents (92%-99%) indicated that they were confident with all 14 BCCDP skills assessed.

Most respondents were confident they could use the BCCDP skills in practice

Figure 5: Percentage of respondents who indicated they were confident about 14 BCCDP skills

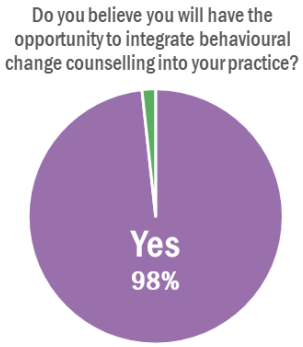


Opportunity to Use BCCDP Skills

Most survey respondents (98%) indicated that they will have the opportunity to integrate behavioural change counselling into their practice. For those who responded that they will not have the opportunity, time and human resources were listed as barriers.

Almost all respondents will have the opportunity to integrate BCCDP skills into their practice

Figure 6: Percentage of respondents who indicated they will have the opportunity to integrate BCCDP skills into their practice



What are the barriers?

"Time constraints,

not enough providers for patient need

(always max booked with no time between patients)

and not enough support staff

(social work, dietary, etc)"

Plan to Use BCCDP Skills

Similarly, most survey respondents (97%) indicated that they plan to integrate behavioural change counselling into their practice.

Almost all respondents plan to integrate BCCDP skills into their practice

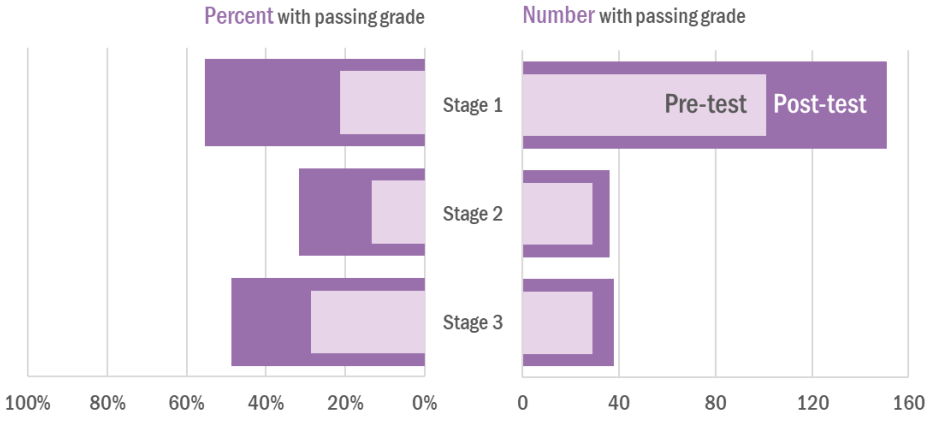
Figure 7: Percentage of respondents who indicated they plan to integrate BCCDP skills into their practice

Competency in BCCDP Skills

For all three stages, a higher percentage of respondents passed the post-test than passed the pre-test. It is important to note that this improved competence cannot be attributed solely to selection bias by assuming that only those who passed the pre-test went on to complete the post-test. For example, in Stage 1, 101 individuals passed the pre-test, but 151 passed the post test. So even if all 101 who passed the pre-test went on to complete the post test, there were still 50 (50% increase) more respondents who passed the post-test. For stage 2 and 3, 7 (24% increase) and 9 (31% increase) more people respectively passed the post-test than passed the pre-test.

Competency improved from pre-test to post-test across all three stages

Figure 8: Percent and number of respondents with a passing grade on the pre- and post-test competency questions

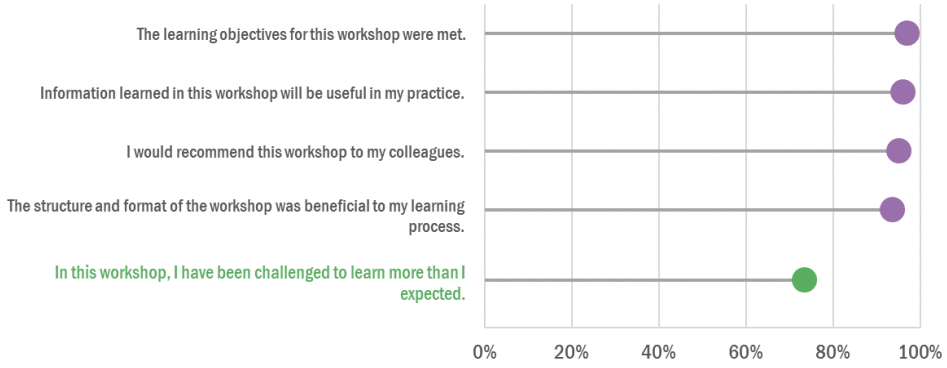


Satisfaction with BCCDP Virtual Workshops

Most survey respondents (95%-97%) indicated that they agreed with 4 of the 5 satisfaction statements. Fewer survey respondents (75%) agreed that they had been challenged to learn more than expected. This finding was similar to that reported by those who completed the E-Modules survey.

Most respondents were satisfied with the BCCDP and learned more than what was originally expected through the program.

Figure 8: Percentage of respondents who agreed with 5 satisfaction statements

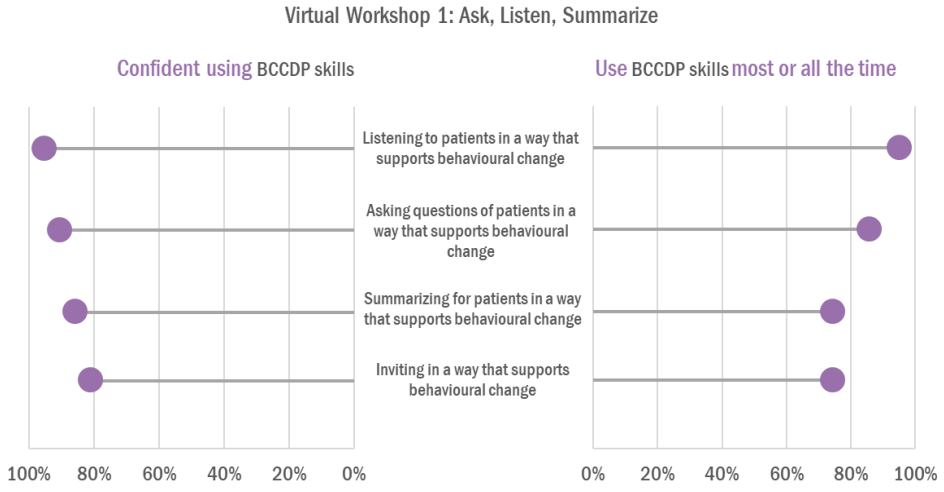


Use of and Confidence with BCCDP Skills

For the *Ask, Listen, Summarize Virtual Workshop*, most respondents reporting being both confident (81%-95%) using the BCCDP skills and using them most or all the time (75%-95%).

Confidence in using the BCCDP skills mirrored use of the skill most or all the time

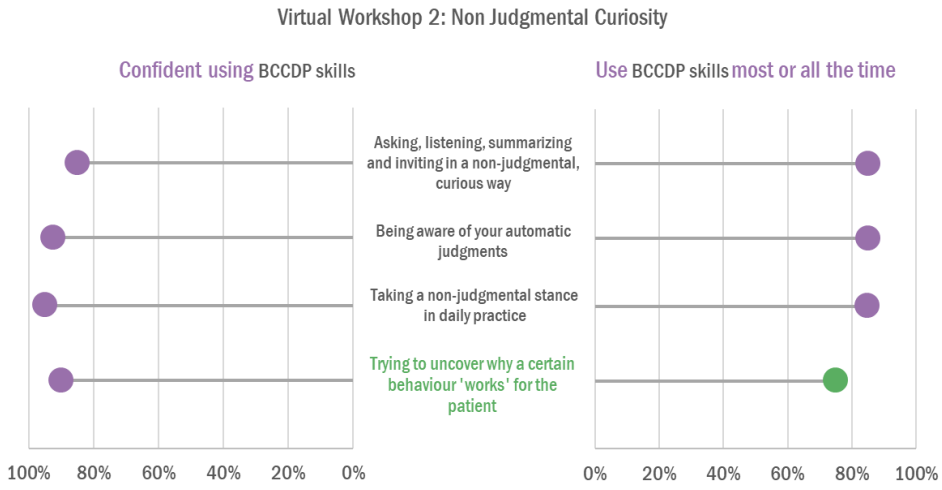
Figure 9: Percentage of respondents who reported being confident using 4 BCCDP skills and using those skills most or all the time



For the *Non-Judgmental Curiosity Virtual Workshop*, most respondents reported being both confident (85%-95%) using the BCCDP skills and using them most or all the time (75%-85%). There was a disconnect between 90% of respondents who reported being confident in trying to uncover why a certain behaviour 'works' for the patient and 75% using that skill most or all the time.

90% of respondents were confident trying to uncover why a certain behaviour 'works' for the patient, but 75% used that skill most or all the time

Figure 10: Percentage of respondents who reported being confident using 4 BCCDP skills and using those skills most or all the time



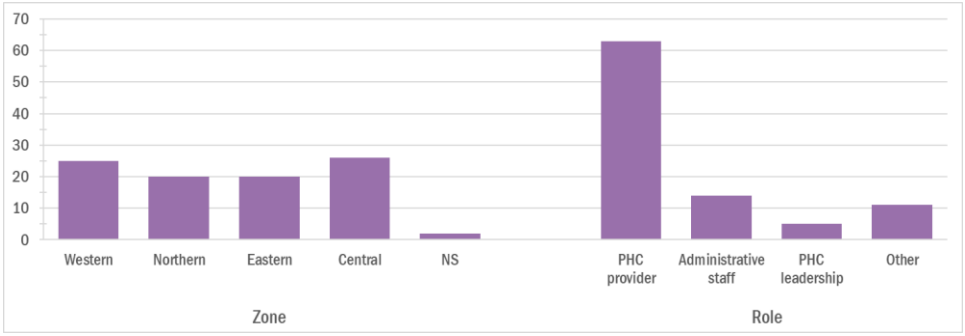
Qualitative Analysis

Emerging Themes from Staff Survey and Leadership Interviews

Of the 938 PHC staff contacted, 93 completed the survey (response rate =10 %). Of these, 57 (61%) reported accessing BCCDP resources.

Most respondents were PHC providers with broad representation from across the province

Figure 1: Number of survey respondents by zone and role



All Respondents

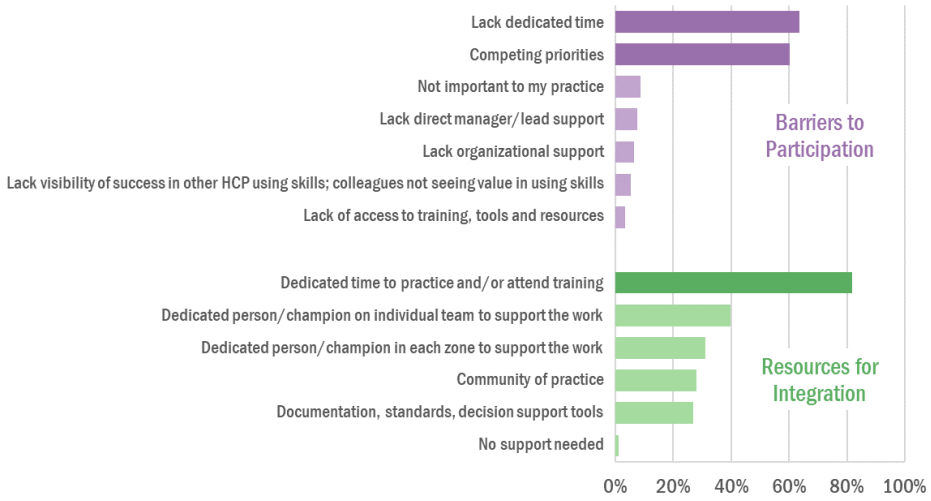
All 93 respondents completed survey questions addressing the following topics.

Barriers and facilitators to BCCDP participation and integration

Most survey respondents (60%-63%) indicated that lack of dedicated time and competing priorities were barriers to participating in the BCCDP. Not surprisingly, most respondents (82%) also indicated that dedicated time to practice and/or attend training is a key resource for supporting healthcare providers to integrate behaviour change counselling into their practice.

Dedicated time is both a barrier to BCCDP participation and a resource for BCCDP skill integration

Figure #: Percent of respondents (n=93) reporting each of 7 barriers to participation and 6 resources for integration

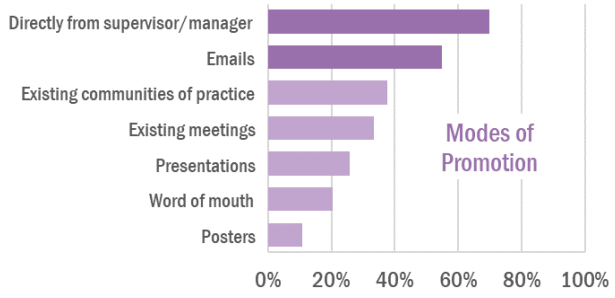


Best ways to promote the BCCDP to PHC staff

Most survey respondents indicated that the best way to promote the BCCDP was through direct communication (70%) with superiors followed by email (55%), communities of practice (38%), meetings (33%), and presentations (26%).

Direct communication with superiors and email are best for promoting BCCDP among PHC staff

Figure #: Percent of respondents (n=93) reporting each of 7 ways to promote BCCDP to PHC staff



Respondents who accessed BCCDP Resources

Of the 93 respondents, 57 (61%) accessed BCCDP resources.

Content accessed

Of the 57 respondents who access BCCDP content,

- 52 (91%) completed the first E-Module
  - 19 of the 52 (37%) completed all 8 E-Modules (see table #3)
- 5 (9%) did not complete any E-Modules due to a lack of time or other reasons
- 31 (54%) completed at least one virtual workshop (see table #4)
- 26 (46%) did not complete any virtual workshops, mostly due to lack of time (n=17; 65%), not relevant to practice (n=4; 15%), lack of support from leadership (n=2; 8%), or redundancy (n=2; 8%)

Table 3: Number of respondents completing each E-Module

Stage	E-Module	n
PHC Foundations of Behaviour Change	Module 1: Introduction and Theory	52
	Module 2: Ask, Listen, Summarize, Invite	51 - 0
	Module 3: Non-Judgmental Curiosity	46
	Module 4: Motivational Argument, Ambivalence, Resistance	42
PHC Building on Behaviour Change	Module 1: Define Behaviour, Readiness Assessments	30
	Module 2: Behaviour Modification	25
PHC Comprehensive Approach to Behaviour Change	Module 1: Distress, Well-being, 4S's	22
	Module 2: Replacing the Function, Stress Reduction	19
	Completed modules (modules not identified)	2

Table 4: Number of respondents (n=31) completing each Virtual Workshop

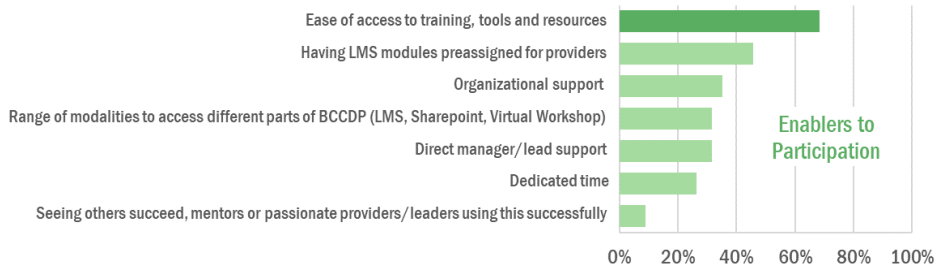
Virtual Workshop	n	%
Ask, Listen, Summarize, Invite	23	74%
Non-judgmental Curiosity	17	55%
Motivational Argument, Ambivalence, Rolling with Resistance	13	42%
Defining Behaviour	9	29%
Readiness Assessment	8	26%
Working with Green Lights: Goal Setting	8	26%
Working with Yellow Lights	9	29%
Working with Red Lights	5	16%
Sustaining the Change: Shaping, Reinforcement Management, & Stimulus Control	2	6%
Distress / Well-being Assessment	2	6%
The 4S's	2	6%
Replacing the Function, Stress Reduction	2	6%
Completed modules (modules not identified)	7	23%

Enablers to BCCDP Participation

Most survey respondents (68%) indicated that ease of access to training, tools and resources enabled participation in the BCCDP. Other enablers identified at least 1 in 4 respondents included having LMS modules preassigned for providers, organizational support, range of modalities, direct manager/lead support, and dedicated time.

Ease of access to training, tools, and resources enable participation in BCCDP

Figure #: Percent of respondents (n=57) reporting each of 7 enablers to participation



Incorporation of BCCDP knowledge and skills in daily work

Most survey respondents (48, 84%) reported that they incorporated at least one BCCDP skill into their daily work. The two most reported skills to be incorporated into practice were ask, listen, summarize, and invite (70%) and non-judgmental curiosity, managing ambivalence, and rolling with resistance (60%). Other skills identified by at least 1 in 3 respondents included goal setting and shaping, traffic light readiness assessment, taking change off the table and maintaining the relationship, and defining a behaviour.

BCCDP skills incorporated by the most respondents were ask, listen, summarize, invite & non-judgmental curiosity

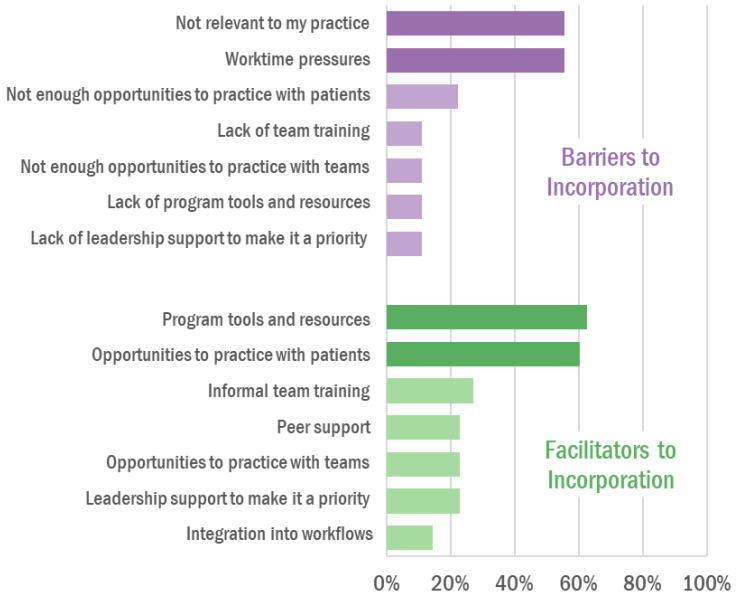
Figure #: Percent of respondents (n=57) who incorporated BCCDP skills into their daily work

Of the 48 respondents who incorporated at least one BCCDP skill into their daily work, most reported having the program tools (63%), resources, and opportunities to practice with patients (60%) as facilitators to incorporating the BCCDP skills into daily work. Informal team training was also reported by at least 1 in 4 respondents.

Of the 9 respondents who did not incorporate at least one BCCDP skill into their daily work, most (56%) reported relevance and worktime pressures as barriers.

Relevance and worktime pressure are barriers to incorporating BCCDP skills into work while tools, resources, and opportunities to practice are facilitators

Figure #: Percent of respondents reporting barriers (n=9) and facilitators (n=48) to incorporation of BCCDP skills into daily work

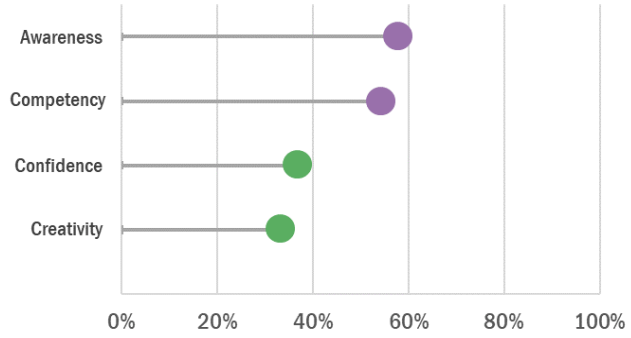


Competency

Most survey respondents rated their behaviour change skills at the early part of the learning continuum: awareness (58%) and competency (54%). Slightly fewer felt their behaviour change skills were at the upper end of the continuum: confidence (37%) and creativity (33%).

More respondents rated their overall behaviour change skills at the awareness and competency end of the learning continuum than at the confidence and creativity end

Figure #: Percentage of respondents who rated their behaviour change skills across the 4 stages of the learning continuum



Satisfaction with care provided as result of BCCDP participation

Of the 57 respondents who accessed BCCDP resources, 50 rated their satisfaction with the care they provided patients as a result of participating in the program. Most (82%) indicated that they were satisfied or very satisfied with their care provision.

Plans to continue using BCCDP skills

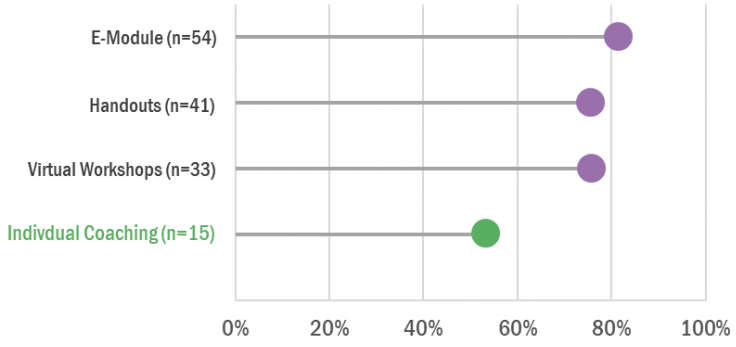
Most respondents (70%) indicated that they were likely or very likely to continue using behaviour change counselling in their practice.

Usefulness of BCCDP Resources

See below graph. Note, the survey did not capture the amount of people who actually accessed individual coaching. Anecdotally, almost no employees took advantage of the individualized virtual coaching opportunity.

Most respondents rated the E-modules, Handouts, and Workshops as useful; fewer rated the Individual Coaching as useful

Figure #: Respondents rating each BCCDP resources as useful or very useful as a percentage of those (n) who used the resource



Community of Practice

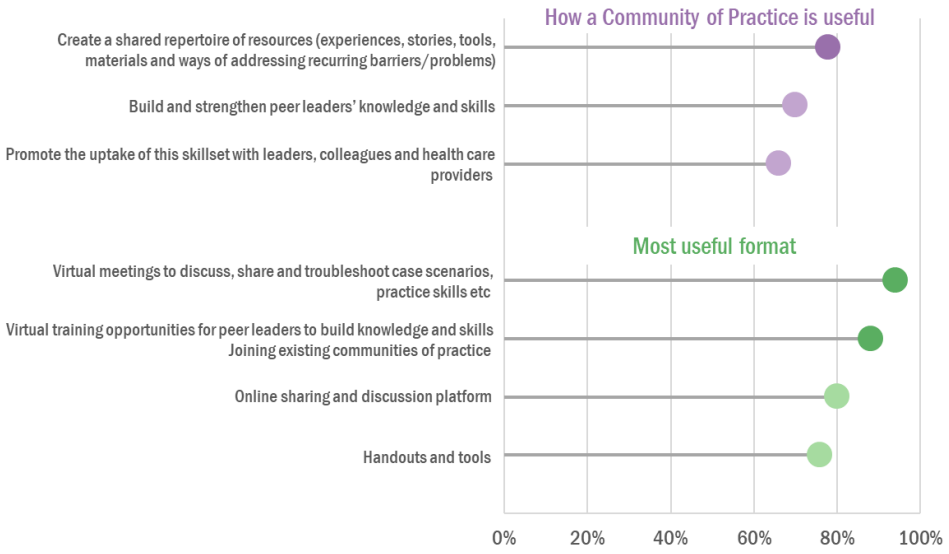
The 57 respondents who accessed BCCDP content scored the usefulness of a community of practice (1= not useful to 5 = very). The average score was 3.6 out a 5. For the 7 respondents who reported that a community of practice would not be useful (score = 1), lack of time and too many communities of practice were the leading reasons for their rating.

Among the 50 respondents who indicated a community of practice was to some degree useful, the most frequently reported use was to create a shared repertoire of resources (78%). Building and strengthening peer leaders' knowledge and skills and promoting the uptake of this skillset with leaders, colleagues and health care providers were also reported by at least 2 out of every 3 respondents.

Virtual options for meetings, training, and sharing/discussion were most frequently reported as the most useful format (80%-94%). Handout and tools were also endorsed by 3 of 4 respondents.

Communities of practice have several key uses and are most useful when they occur in a virtual format

Figure #: Percent of respondents (n=50) reporting how a community of practice is useful and the most useful format



Required Training

The 57 respondents who accessed BCCDP content scored the degree to which individuals in various roles should be required to participate in BCCDP training (1= not required to 5 = strongly required). The highest average score was assigned to all healthcare providers (3.8), followed by PHC leadership (3.7) and administrative staff (2.4).

Many respondents recommended that the 4 modules in Stage 1 be required learning for HCPs and leadership (86% and 82-89%, respectively). Fewer respondents (40-53%) recommended that the 4 modules in Stage 1 be required for administrative staff (40-56%). Although less than Stage 1, approximately 75% of respondents recommended that the modules in Stage 2 and 3 be required for HCPs, and approximately 60% of respondents recommended that Stage 2 and 3 modules be required for

leadership. Similarly, to Stage 1, fewer respondents (21-23%) recommended that the modules in Stage 2 and 3 be required for administrative staff.

Percentage of respondents (n=57) recommending required BCCDP training

Stage	E-Module	Healthcare Providers	PHC Leadership	Administrative Staff
PHC Foundations of Behaviour Change	1. Introduction and Theory	49 (86%)	50 (88%)	30 (53%)
	2. Ask, Listen, Summarize, Invite	50 (88%)	51 (89%)	32 (56%)
	3. Non-Judgmental Curiosity	49 (86%)	48 (84%)	29 (51%)
	4. Motivational Argument, Ambivalence, Resistance	49 (86%)	47 (82%)	23 (40%)
PHC Building on Behaviour Change	1. Define Behaviour, Readiness Assessments	44 (77%)	36 (63%)	13 (23%)
	2. Behaviour Modification	42 (74%)	36 (63%)	13 (23%)
PHC Comprehensive Approach to Behaviour Change	1. Distress, Well-being, 4S's	41 (72%)	35 (61%)	12 (21%)

Thematic Analysis

By analyzing provider interview responses and qualitative survey information, three high-level themes were recognized:

1. **Leadership support,** which is essential in facilitating the implementation and integration of the BCCDP,
2. **Provider engagement** with the BCCDP material, and
3. **Provider impact and satisfaction** with the BCCDP information, uptake, and potential impacts.

All three themes can be directly associated with the BCCP Evaluation Framework.

Leadership Support

Leadership members having the physical capability and skills to engage with the BCCDP program was extremely important for both program facilitation and HCP engagement/support. One interviewee stated, "it is really, really, important that managers buy-into what they are trying to do. If management doesn't support the changing of the clinical culture, then it's not going to go anywhere".

Leaders who understand the value of the BCCDP for both patients and HCPs (i.e., psychological capability) are better able to encourage and support others to engage with the program. "Buy-in from leadership", and "sharing personal positive experiences on how the program helped provide care" are both extremely beneficial processes that leaders can utilize to support HCPs. Leaders who effectively use the skills from the BCCDP are more likely to influence their employees to take on this approach. One interviewee stated, "if our management and the people that are the face of this change can't

communicate in a nonconfrontational, non-judgmental way, it will compromise the ability for them to facilitate and lead change".

Leaders who are motivated to incorporate BCCDP skills into their practice can positively impact their staff. Meeting individuals where they are at with tools and knowledge for further learning and having conversations with employees were noted as being an important aspect in motivating staff to engage with the program material. One provider stated "it's important to learn together, practice together, and show a bit of your vulnerabilities along the learning curve together. It matters.".

For leaders to be able to support and motivate staff, they must be "living and breathing BCCDP information, not just endorsing it". An important quote, that was stated by an interviewee, which encompasses this idea of leadership providing motivation to staff is, "if an airplane engineer talked to you for two hours and then left you alone to build the engine, could you do it? No. You have to start working where people are".

Finally, leaders must be able to provide the physical and social opportunity for themselves and HCPs to engage with the BCCDP material. One interviewee stated "people just need the meetings to be able to come together as a group to reflect. Where are you at? Where are you going? Have you achieved that goal? Are you there yet? Were you able to see whether this was being integrated into practice, and what are the barriers like?".

Provider Engagement

HCPs identified that motivation was key to implementing skills into practice. Many interviewees stated that the BCCDP principals and modules cannot "just be considered an item to check off a list". HCPs need to see value in the BCCDP in order to be motivated to engage with the materials and use the skills in practice. One interviewee stated that the BCCDP must be portrayed by leadership as "time you should dedicate. This is how we want you to help better your patients".

HCPs must be given opportunities (both physical and social) to complete the BCCDP. In terms of physical opportunities, employees must be given the time to properly engage with the material, to ask questions, and to discover their own vulnerabilities. An important social opportunity identified was the shift towards a culture of behaviour change in PHC. One interview stated, "we want employees to create the change in the medical model where we have been telling patients what to do, when to do, and how to do it". By taking the time to learn, practice, support others and incorporate skills daily practice, a culture shift is possible. An interviewee said "staff are interested and open to learn. From conversations, they seem to be applying BCCDP principles to work", and another said, "behavioral conversations have been incorporated into physician reports".

Finally, for employees to engage with the BCCDP material, they must have the physical and psychological capabilities to be able to do so. Individuals must feel that they have the physical ability, as well as knowledge, to engage and integrate the information appropriately. An employee's readiness to engage and their optimism, (i.e., "positive, enthusiastic and impassioned attitudes for the program"), were noted as being important when developing such capabilities. Importantly, the integration of a local

champion, who is working to raise awareness and “selling the idea that there is something to be learned”, within healthcare teams was noted as extremely influential in helping their colleagues to develop their capabilities.

Provider Impact and Satisfaction

Providers are more motivated to use the BCCDP knowledge and skills when they see their value. Interviewee comments around this idea include “these skills are not just for healthcare, it’s skills for your family, it’s skills to manage your people”, “I think it would benefit anybody, anywhere, anytime, in any setting”, and “I just really can’t see a future where this is not a critical component of how we do healthcare”. Another interviewee said “the BCCDP is amazing – it works to bring successful relationships with patients”.

When providers' physical and psychological capabilities are being met, their ability to effectively use the skills in practice and their satisfaction with the care they provide is enhanced. From a physical capability perspective, the BCCDP content and format was noted as practical, useful, and effective. One of the interviewees noted that the BCCDP was an “attainable program. It was self-directed and user friendly”, which allowed for easier development of skills. Being provided the time and environment to “play with” the BCCDP resources was noted as providing significant value, especially in terms of becoming aware of one's vulnerabilities and developing strengths to overcome them, aspects of improving one's psychological capability.

Finally, being given the opportunity to learn about the influential impact of the BCCDP on the patient is noted as having significant positive effects on provider satisfaction. One interviewee noted that “sharing personal, positive experiences on how the program helped provide care” can be extremely influential encouraging others to consider using these skills. A personal experience from a provider, speaking to how BCC can build successful relationships with patients, summarizes this idea well: “I would love to go back to when I had a patient in front of me, so that I can reflect and understand that they didn’t really give a darn if their arm went up higher than this, they only needed to reach the top shelf. They didn't want to do all the work to get the full range back. It didn't matter to them, so there would be a variety of scenarios that I never really asked “what was important to them?”. So, it became this holy mackerel mind-blowing thing. You know, you’re not going to fix someone who's happy with not being perfect. They're happy with the function that they have. So, I should have focused on what was important to them".

Key Lessons Learned/Takeaways

Main Objectives	Lessons Learned	Key Takeaways
Objective 1 - Examine whether more participation in training and practice opportunities has an impact on the application of behaviour change counselling (BCC) skills to practice.	- Individuals who participated in the program had higher levels of perceived competency and confidence in applying skills to practice. - The majority of participants felt satisfied or very satisfied with the care they provided as a result of participating in the program.	- The majority of participants indicated that they would continue to use BCC skills in their practice.
Objective 2 - Examine whether levels of capability, opportunity, and motivation (i.e., COM-B) have an impact on implementation of skills in practice.	**Capability** - The format of the BCCDP was viewed to be useful and practical, especially the variation in program offerings. - Participants showed improvements in knowledge after participating in the e-modules, and those who participated in the virtual workshops felt it was time well-spent in increasing their competency. - The majority of participants rated their overall skills in behaviour change to be at the "awareness" and "competent" end of the learning continuum, which is not surprising, given that most participants stated that the program content was new to them. - Family practice nurses and chronic disease teams had the highest rates of participation in the program.	**Capability** - Enhancements to the program were recommended to be minor, in line with participants' learning needs over time and to keep the skills relevant and top-of-mind. - A limitation to the program is that it does not measure participant skill development objectively (i.e., direct observation, assessments). That said, this is challenging to do, because there is no gold standard for measurement, and it is known from previous studies that people generally do not like to be objectively assessed on their skill development (Vallis et al., 2019). - A recommendation is to explore opportunities, in particular for peer leaders to be assessed over time, to further support their knowledge and skill development. This is

		especially critical to ensure sustainability of the program delivery model and contribute to further enhancement of skills across the portfolio.
	Opportunity - Time to participate in training and practicing the skills was noted several times throughout the evaluation as a significant enabler to knowledge and skill building. - Survey participants felt that the addition of localized peer leaders would further support their skill uptake and integration into practice. - Sharing stories of successful use and integration of skills was also noted as an important way to increase awareness and buy-in for BCC.	Opportunity - Time to participate in training and practicing skills needs to be formally supported and endorsed by all leaders. - Leaders need to engage with program resources to build their skills in BCC, which helps facilitate the shift towards a culture of self-management within PHC. - A community of practice was recommended; virtual synchronous opportunities for HCPs to discuss, troubleshoot, and learn from others was described as the most useful format.
	Motivation - The majority of participants felt that modules 1-4 (Foundations of Behaviour Change) should be required for leaders and HCPs in PHC to complete - In the Eastern Zone it was shown that leaders who visibly endorsed the program, embedded BCC skills into their own practice (i.e., through their leadership team meetings, conversations), and expected staff to participate in the BCCDP had higher e-module completion rates than any other zone.	Motivation - Friendly competitions to complete the e-modules could be an effective way to improve completion rates. - It was noted that participants would be more motivated to participate in the BCCDP and use program knowledge and skills if they were endorsed by leaders through formal mechanisms such as performance appraisals, team agreements, learning needs assessments, and new staff orientation.

Objective 3 - Determine the enablers of successful integration of skills.	- Most survey respondents indicated that ease of access to training, tools and resources enabled their participation in the BCCDP. - Other enablers included having e-modules preassigned in LMS, organizational support, range of modalities, direct manager/lead support, and dedicated time. - dedicated time and competing priorities were the most cited barriers to participation in the program. - BCC skills take time to develop and are more complex than anticipated; this is referenced by study participants' lack of confidence in administering skills in the later stages of the program (i.e., psychosocial and distress issues). - The results of this evaluation suggest that family practice nurses, licensed practical nurses and allied health care providers have both the interest and opportunity to integrate BCC into their practice. - A frequently cited enabler was leadership support, which substantiates what is already known about BCC practice integration. - Survey participants suggested that they would prefer to hear about program opportunities from their frontline leaders over other communication methods.	- Since PHC includes the delivery of care across the lifespan, continuum of care and disease trajectory, all HCPs working in PHC should have at least a level of awareness of the BCC knowledge and skills. - It will be important for leaders to determine which providers have the capacity and capability to deliver BCC most effectively. - Leaders at all levels are critical to the endorsement of self-management and behaviour change, from senior leaders who set the vision and define strategic priorities, to front line leaders supporting employees with the time to participate in training, opportunities to practice skills, and to embed behaviour change knowledge and skills into everyday practice. - For leaders to effectively promote the importance of BCC, they need to understand the core concepts and believe in their value. They can do this by taking part in training opportunities to grow their own skills and look for opportunities to integrate skills into their own leadership practice.

Recommendations:

Recommendations are based on the evaluation findings and listed by BCCDP Framework enablers and COM-B element (see Appendix). **Note: COM-B elements are represented as applicable to the appropriate enabler.**

Leadership Support

Capability

- **Development of a BCCDP workshop for leadership.**
  Per the interview findings: the development of a "concise, hour-long presentation facilitated with a 4–5-page document tailored to a leadership audience, showing leaders how the behavior change skills apply to leadership functions, change management, staffing, performance appraisals and working with employees around their own health".

- **Leaders at all levels should participate in team-based practice sessions and/or virtual workshops.**
  Leaders engaging with staff, meeting individuals where they are at with tools and knowledge for further learning, and having conversations were noted as being an important aspect in motivating staff to engage with the program material.

Opportunity

- **Leaders at all levels should complete the *Foundations of Behaviour Change* e-modules 1-4 to support uptake in HCPs and use the behaviour change skills as part of their leadership style.**
  It is important for leaders to use behaviour change counselling skills in conversations with employees, which also helps them to promote the value of the program. "If our management and the people that are the face of this change can't communicate in a nonconfrontational, non-judgmental way, it will compromise the ability for it to facilitate and lead change."

Team Culture and Readiness

Opportunity

- **Dedicated time built into employee schedules for BCCDP.**
  Evaluation findings suggest that "people just need the meetings to be able to come together as a group to reflect. Where are you at? Where are you going? Have you achieved that goal? Are you there yet? Were you able to see whether this was being integrated into practice, and what are the barriers like?"

Motivation

- **Behaviour change counselling knowledge and skills are recognized and incorporated as core competencies for all PHC HCPs.**
  Building knowledge and skills into existing learning needs assessments, HCP orientation materials, performance reviews, and team agreements, for example. Evaluation findings suggest that BCC must be portrayed, by leadership, as "time you should dedicate. This is how we want you to help better your patients." This work can draw from the BCCDP competency framework.

- **Consider incentives to complete the program**.
  This may include certificates of completion when the program is complete; recognition from the team when training is completed; email notification to a manager that an employee has completed training; kudos to specific teams around completing training.

Peer Leaders/Communities of Practice

Opportunity

- **Community of Practice**

  Create a team of HCPs who have an interest and confidence in skills, to help support the development of a culture of behaviour change and self-management support. Evaluation findings showed staff who have the highest competency in the skills also report the highest confidence in the skills.

- **Incorporate zone-based champions**
  The integration of a local champion, who is working to raise awareness and "selling the idea that there is something to be learned", into healthcare teams was noted as extremely influential in assisting employees in developing their capabilities, by being both accessible and receptive. Consider a formal position that is devoted to building capacity across each zone. For example, a 1.0 FTE role per zone, with 0.5 FTE focus on behaviour change support and 0.5 FTE to deliver wellness programs.

Training and Professional Development

Capability

- Involve HCPs with high levels of competency in BCC skills in delivering BCCDP
  The evaluation findings suggest staff who have the highest competency in the skills also report the highest confidence in the skills.

- Require completion of e-modules 1-4 every two years
  Many respondents said that they would continue to use the program skills in everyday practice by "revisiting the information annually" and "accessing more education as it becomes available in order to learn more."

- Consider virtual workshop enhancement
  Examples include: more time to practice and offering sessions at a variety of times. Respondents would like "more time to try scenarios", would like prerecorded virtual support meetings as "current times conflict with dedicated patient care time" and would like to be given the dedicated time for "practices to learn together. Consider concentrated themes monthly. Use creative ways to showcase the skills to staff i.e., videos, behaviour change tip of the month.

- Communications approach
  Use behaviour change science strategies to engage staff. "Eastern zone is doing this..." social norms. Decreased no shows, decreased unnecessary repeat appointments, self-management skills for the patient to manage in their own life. Emphasize ability to take pieces of the program and integrate into practice. Blog.

Opportunity

- An in-person staff education day to practice activities and promote team building.

- Create on-going opportunities for health care providers who have reached the "creativity" level of their skills
  For example: Complex case scenario practice, using BCCDP in a group setting and in leadership style. Finally, many respondents said that they would continue to use the program skills in everyday practice by "revisiting the information annually" and "accessing more education as it becomes available in order to learn more."

Motivation

- Maintain the current format of training
  BCCDP was an "attainable program. It was self-directed and user friendly", which allowed for easier development of skills. Being provided the time and environment to "play with" the BCCDP components was noted as providing significant value, especially in terms of becoming aware of

one's vulnerabilities and developing strengths to overcome them, aspects of improving one's psychological capability. The format of the BCCDP, being virtual sessions and self-directed material, was noted as a strength to its facilitation.

- Share stories of success with staff
  Sharing of BCCDP success stories" to staff was noted as important for motivating individuals to integrate the materials so that similar results could be experienced. Sharing positive outcome stories from providers who have implemented program skills" is important when attempting to enhance the program. This may be done by a "clinical champion in each zone who can lead the discussion at the community of practice" and by "more buy-in from leadership"

- Make the BCCDP required for PHC providers and leaders

  Most respondents felt that all modules should be required for all healthcare providers.

- E-modules 1-4 (Foundations of Behaviour Change) should be optional for administrative staff - (54%) responded below neutral for this question and felt that the BCCDP resources were not strongly required for administrative staff.

- Tailoring the program to target different, specific audiences was mentioned as an idea to enhance its effectiveness.

Supervision and Mentorship

Motivation

- Develop a competency program for BCC champions
  This might include reviewing and rating skills by external evaluators. Look to the work done for motivational interviewing.

Integration into Team Practices

Opportunity

- Identify specific time in staff schedules to work on behaviour change counseling skills
  Evaluation findings suggest that barriers like time constraints, not enough providers for patient need (always max booked with no time between patients) and not enough support staff (social work, dietary, etc.) impact their ability to engage with the BCCDP.

- Develop an EMR documentation template
  Corresponding to behaviour change skills (upload to Accuro, MedAccess, One content).

Motivation

- Demonstrate/communicate how BCC can save clinical time
  For example, decreased no shows, decreased unnecessary repeat appointments, self-management skills for the patient to manage in their own life. This could be integrated as part of program materials, communications etc. This may improve motivation to develop and use the skills in clinical practice.

Monitoring and Evaluation

Capability

- Develop a tool to measure and monitor clinician competency in BCC.

Opportunity

- Promote a culture of SMS
  For example, this may include a public campaign to emphasize the importance of self-management and behaviour change, and/or new programming options for Nova Scotians in self-management support.

Motivation

- Streamline evaluation framework
  Based on the results of this evaluation, consider streamlining evaluation and data collection tools. Determine what information is required to facilitate the recommendations in this report.

- Consider opportunities for patient focused evaluation of impact of BCCDP
  Evaluating the impacts of the program on patients, via their interactions with HCPs.

Recommendations:

Note: Recommendations are not required in each area of the COM-B, as different COM-B elements are more relevant to different enablers and recommendations are based on evaluation findings.

	Capability	Opportunity	Motivation
Leadership support *Formal leaders participate in training & support HCPs in training & other activities to develop BC knowledge They understand the long-term commitment required to realize a paradigm shift in care delivery & support sustainability*	• Develop BCCDP workshop for leadership • Leadership participates in team-based practice sessions &/or virtual workshops	• E-modules 1-4 are required for leaders to support uptake in HCPs • Leadership use the BCC skills as part of their leadership style	
Training and professional development	• HCPs with high level of competency in	• Host in-person staff education day to practice	• Maintain current format of training

The program provides a range of formal opportunities for HCPs to participate in training, based on their readiness. The program supports formal leaders and HCPs to further develop knowledge and skills and integrate into practice.	BCC skills help deliver BCCDP • Require biennial completion of e-modules 1-4 • Enhance virtual workshops • Develop Communication Strategy for BCCDP	activities and promote team building. • Create on-going opportunities for HCP who have reached the "creativity" level to practice their skills	• Share stories of success with staff • Make E-modules 1-4 BCCDP required for all PHC providers • Make E-modules 1-4 optional for PHC admin staff • Tailoring BCCDP to specific audiences to enhance its effectiveness.
Resources *Direct & indirect resources aligned to enable uptake of BC knowledge and skills~~,~~ and the use of BC interventions.*		• Build dedicated time into employee schedules for BCCDP	
Integration into workflows *BC approaches must be integrated within the existing flow of work (i.e., patient assessments, integration into group programming, forms, meetings) to support behaviour change and ensure sustainability.*		• Identify specific time in staff schedules to work on BCC Skills • Strengthen the support for health care providers to integrate BC into their practices at the Zone level • Develop an EMR documentation template	• Demonstrate/communicate how BCC can save clinical time
Culture and readiness *Celebrated and embraced, BC is embedded in our culture as evidenced in the day-to-today work offered by program and service areas. BC is integrated into the vision and principles of program and service areas and is implemented into operational frameworks.*		• Promote a culture of self-management support through leadership buy-in and communication, integration into workflows, etc.	• Recognize and incorporate BCC knowledge and skills as core competencies for all PHC HCPs • Consider incentives to complete the program
Monitoring and evaluation *Monitoring and evaluation are essential enablers to identify both HCP and patient success.*	• Develop a tool to measure and monitor clinician competency in BCC		• Streamline evaluation framework • Consider opportunities for patient focused evaluation of impact of BCCDP
Community of Practice *BC peer leaders are HCPs who work collaboratively with formal leaders (manager and/or team lead) and the BCCDP team to translate BCC knowledge and skills into everyday practice. Over time, a community of practice of peer leaders will be implemented.*		• Incorporate zone-based champions as formal roles • Create a BCC Community of Practice	
Supervision and mentorship *Supervision and mentorship are required for peer leaders and trained HCPs.*			• Develop a competency program for BCC champions

Conclusions

The results of this mixed-methods evaluation substantiate and add to the literature base on self-management support. It was shown that a system-level BCCDP can be implemented effectively in a PHC setting by ensuring that participants have the capability, opportunity, and motivation to participate in and integrate learned skills into practice. Key enablers such as leadership support and time to participate in training and practice skills were identified as critical factors to successful implementation, while barriers include a lack of time and competing priorities. BCC is a skillset that takes time to develop; it needs to be applied regularly in both practice and real-life scenarios to become embedded into clinical practice. BCC should not be viewed as an "add-on" to clinical practice; instead, it is the foundation of a strong patient-provider relationship and is critical to high quality chronic disease prevention and management. Shifting the focus from the traditional medical model to one of self-management support and behaviour change takes time, but the impacts are worth the effort. Health care systems that prioritize and enable this shift while removing and/or minimizing the barriers create the conditions for change, enabling patients to become active participants in their health care, to improve their experience with the health system, and to live healthier lives.

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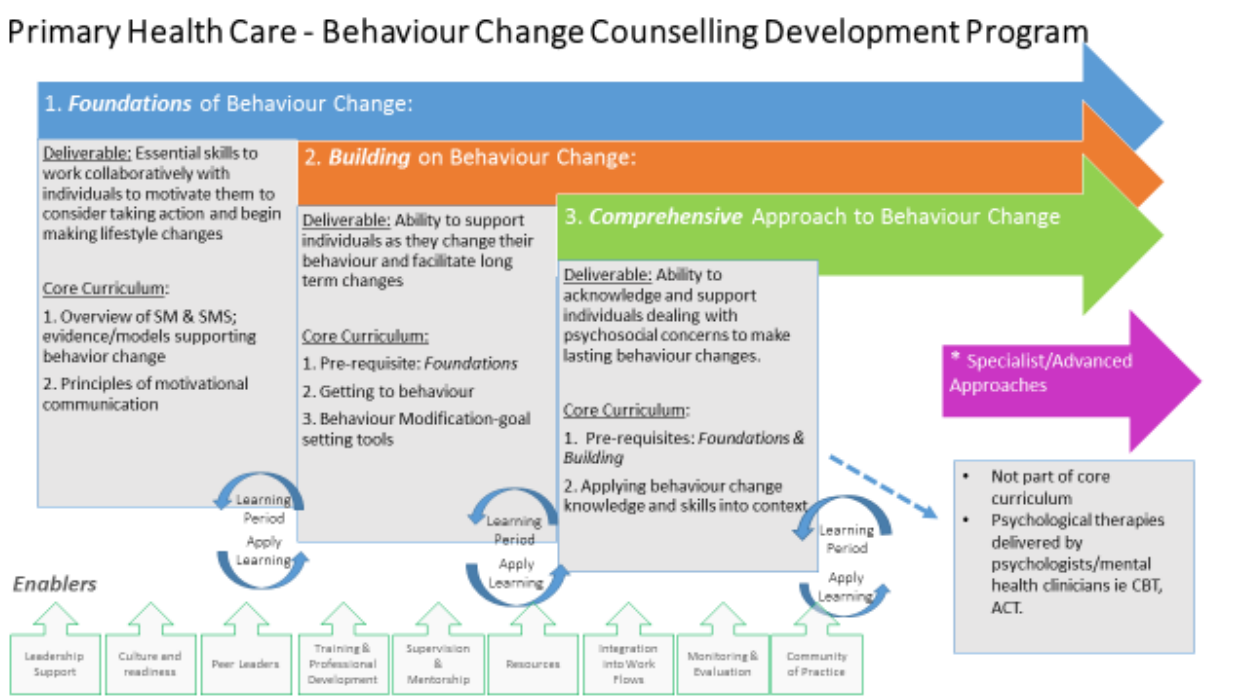
Appendix A

Program Model, E-modules and Workshops



List of E-modules

1. PHC Foundations of Behaviour Change – Module 1: Introduction and Theory
2. PHC Foundations of Behaviour Change – Module 2: Ask, Listen, Summarize, Invite
3. PHC Foundations of Behaviour Change – Module 3: Non-Judgmental Curiosity
4. PHC Foundations of Behaviour Change – Module 4: Motivational Argument, Ambivalence, Resistance
5. PHC Building on Behaviour Change – Module 1: Define Behaviour, Readiness Assessments
6. PHC Building on Behaviour Change – Module 2: Behaviour Modification
7. PHC Comprehensive Approach to Behaviour Change –Module 1: Distress, Well-being, 4S's
8. PHC Comprehensive Approach to Behaviour Change – Module 2: Replacing the Function, Stress Reduction

List of Workshops

1. Ask, Listen, Summarize, Invite
2. Non-Judgmental Curiosity
3. Motivational Argument, Ambivalence, Rolling with resistance
4. Defining Behaviour
5. Readiness Assessment
6. Working with Green Lights - Goal Setting
7. Working with Yellow Lights
8. Working with Red Lights

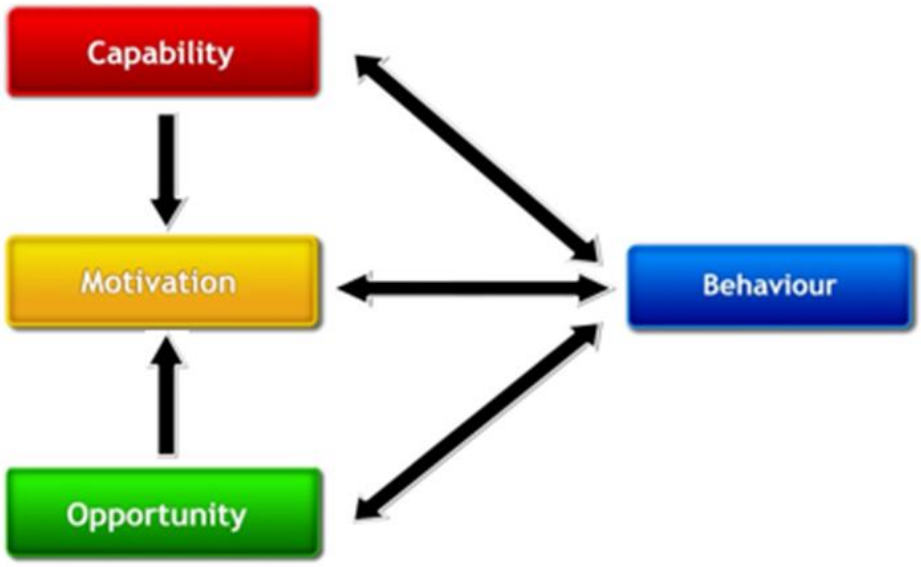
9. Sustaining the change - Shaping, Reinforcement Management & Stimulus Control
10. Distress/Well-being assessment
11. The 4 S's
12. Replacing the function, Stress reduction

Appendix B

Primary Health Care Self-Management Support Conceptual Model

Appendix C

COM-B Model – A System for Understanding Behaviour



(Michie et al., 2014, p. 62)

Appendix D

COM-B Model Components Defined

COM-B model component Definition	**Example**
Physical capability Physical skill, strength or stamina	*Having the skill to take a blood sample*
Psychological capability Knowledge or psychological skills, strength or stamina to engage in the necessary mental processes	*Understanding the impact of CO2 on the environment*
Physical opportunity Opportunity afforded by the environment involving time, resources, locations, cues, physical 'affordance'	*Being able to go running because one owns appropriate shoes*
Social opportunity Opportunity afforded by interpersonal influences, social cues and cultural norms that influence the way that we think about things, e.g. the words and concepts that make up our language	*Being able to smoke in the house of someone who smokes but not in the middle of a boardroom meeting*
Reflective motivation Reflective processes involving plans (self-conscious intentions) and evaluations (beliefs about what is good and bad)	*Intending to stop smoking*
Automatic motivation Automatic processes involving emotional reactions, desires (wants and needs), impulses, inhibitions, drive states and reflex responses	*Feeling anticipated pleasure at the prospect of eating a piece of chocolate cake*

(Michie et al., 2014, p. 63)

Appendix E

Self-Management Support Evaluation Framework:

Long Term Outcome: Health care providers (HCP's) have increased knowledge, skills, and confidence to incorporate a self-management support (SMS) person-centered approach.

Evaluation Question	Indicator (how will we know?)	Data Source	Lead/Timeframe
1. *SMS Skill Development – Behavior Change Counselling Development Program*			
1.1 What training opportunities have been implemented to support HCP/team SMS skill development?	# and type of training opportunities that were made available to PHC staff (i.e.: web based, in person, initiative, by zone, network and cluster)	Training implemented – tracked in excel spreadsheet	Data entered after each session
1.2 What SMS intake and prioritization mechanisms have been developed to determine participation in training?	# and type of mechanisms	Training implemented – tracked in excel spreadsheet	Data entered after each intake/prioritization activity completed.
1.3 Who has participated in SMS skill development training (i.e., leaders, HCPs)? What type of intervention? When?	#, % and type of participants, by modality, by provider type, by practice/team type, by zone, network, cluster by training type (i.e., stage 1, 2, 3)	Training implemented – tracked in excel spreadsheet – Provider Survey	Data entered after each session
1.4 Are the skill development sessions effective in meeting the learning objectives?	# and % of participants who rate presentation/ presenter as Very Good/Excellent # and % of participants who answered yes to whether the initiative successfully meets the stated Learning Objectives	Provider survey	Post training
1.5 How ready were participants to take initial SMS skill development?	# and % of participants who were ready to participate in initial SMS skill development;	Pre-training readiness assessments	Pre-training

1.6 For those who participated in initial SMS skill development, how ready were they to undertake further skill development?	# and % of participants who were ready to participate in further SMS skill development;	Post-training readiness assessment (Provider Survey)	Post-training
1.7 For those who participated in SMS skill development, how ready were they to integrate skills learned into practice?	# and % of participants who were ready to integrate skills into practice	Post-training readiness assessment (Provider Survey)	Post-training
1.8 What are leader's perceptions of the value of SMS skill development for teams in PHC (*in the context of all other priorities*…)	Perception that SMS is a foundational skillset; Evidence of ways leadership has supported PHC providers and teams to implement SMS initiatives (i.e., # of initiatives being implemented, operational supports for teams to embed SMS into workflows etc)	Stakeholder interviews (SMS Task group, Directors, HSMs, HSLs)	1 year post training
2. ***SMS Skill Development: Improved knowledge, skill, confidence[1] and competence***			
Did the Behavior Change Counselling Development Program lead to improvements in participants' <u>Capability</u> to change their practice?			
2.1 Are participants increasing their <u>knowledge</u>?	# and % of participants who have increased knowledge as a result of participating in the SMS skill development initiative (***map to knowledge domains in the BCC Competency Framework)***	Provider survey	Post training
2.2 Are participants increasing their <u>skill</u>?	# and % of participants reporting increased skill as a result of participating in the SMS skill development initiative *(**map to skill domains in the BCC Competency Framework**)*	Provider survey	Post training

Did the Behavior Change Counselling Program lead to improvements in participants' Motivation to change their practice?			
2.3 Are participants increasing their confidence to integrate skills into practice?	# and % of participants reporting increased confidence	Provider survey	Post training
2.4 Do participants have a plan to change their practice?	# and % of participants who plan to make a change in their practice as a result of participation in the SMS skill development initiative	Provider survey	Post training
Did the Behavior Change Counselling Program lead to an improvement in participant's Opportunity to change their practice?			
1.1 1 Do participants perceive they will have the opportunity to implement changes in their practice?	# and % of participants with perceived opportunity to apply SMS skills in practice	Provider Survey	Post-training
1.2 Have participants actually had the opportunity to implement changes in their practice? If yes, what were the enablers? If no, what were the barriers?	# and % of participants who report they have had an opportunity to apply [PSP initiative topic] skills in practice What are the reported facilitators of having the opportunity to use skills in practice (qualitative). What are the reported barriers of having the opportunity to use skills in practice (qualitative).	Provider Survey	Post-training (6 months -1 year)
What is participant's level of competency after completing SMS skill development?			
2.7 What stage of competency, as per BCCDP learning model, are participants at for different skills within the curriculum?	# and % of participants who report being at what level of competency for identified knowledge/skills as per BCCDP competency framework (notes – participants will be at	Provider Survey	6- or 12-months post training

		levels of competencies for varying skillsets) 1) Awareness 2) Competency 3) Confidence 4) Creativity		
2	*Did the Behavior Change Counselling Development Program lead to a change in practice?*			
1.1	Are participants applying what they have learned into practice?	# and % of participants who made a change in practice because of participating in the PSP initiative (i.e., corresponding to the stage of training they received) # and type (clinical, administrative, etc.) of changes (qualitative)	Provider Survey	6- or 12-months post training
1.2	Are practice changes sustained over time?	# and % of participants who were able to sustain changes in their practice	Provider Survey	6- or 12-months post training
1.3	What resources, and supports were the most effective for HCPs in building SMS skillset?	Types of resources and supports identified by HCP's as being most effective (i.e.: online, in person training, communities of practice, time to practice with teams)	Provider Survey	6- or 12-months post training
2	*Behavior Change Counselling Development Program Impacts (Provider Satisfaction and Triple Aim)*			
2.1	Are SMS practice changes leading to improvements in provider satisfaction?	# and % of participants who report an improvement in satisfaction	Provider Survey	6- or 12-months post training
2.2	Do providers participating in behavior change counselling program feel there has been a benefit to themselves and their practice?	# and % of participating providers who Agree/Strongly agree there has been a benefit to themselves and their practice	Provider Survey	Post training 6- or 12-months post training
2.3	Do providers and staff that participate in behavior change counselling program	% of participants who report knowing how to access supports to help	Provider Survey	6- or 12-months post training

	perceive they have resources/supports to improve their clinical and/or administrative practice?	them improve their clinical practice % of participants who report using the resources Of those who access resources, % who report satisfaction with the resource		
2.4	Do providers participating in behavior change counselling program feel there has been a benefit to their patients?	# and % of participating providers who perceive that participating in the SMS skill development initiative has benefited their patients	Provider Survey	6- or 12-months post training

Appendix F

Competency Framework – Behaviour Change Counselling Development Program

Stage 1: Foundations of Behavior Change

A change-based relationship is fundamentally different from how the typical health care provider is trained to deliver health care services. Most HCPs are trained as experts who are in the position of assessing/diagnosing, determining treatments and evaluating outcomes, which can be described as the *'Teach and Tell'* perspective. This program provides awareness of the dangers of teaching and tell and encourages the HCP to replace diagnosis, treatment and outcomes with an alternative option that fundamentally shifts the patient-provider relationship. This alternative is known as description, prediction and choice.

A change-based relationship also acknowledges the importance of adopting a patient-provider relationship that balances bond, task and goal alliances between the patient and provider. Equipped with this content knowledge, health care providers are provided skills in motivational communication techniques.

Stage 2: Building on Behaviour Change

There is a growing amount of evidence supporting the understanding that patient behaviour change is hard. Sustained change requires a significant commitment from the patient. The HCP can guide the patient through the change process by developing skills in isolating the behaviour that needs to be changed (i.e., defining behaviour), assessing readiness and promoting readiness to change. Promoting readiness skills are relevant in situations where individuals are ambivalent (i.e., yellow light) or not ready (i.e., red light). Supporting readiness to change requires knowledge in the area of health beliefs and skills in uncovering the pros and cons of changing (i.e., decisional balance).

Behaviour modification requires altering behavioural patterns. Altering behaviour patterns requires both knowledge and skill in working with the internal and external drivers of behaviour. Internal drivers can be modified using goal setting and behaviour shaping strategies. External drivers can be modified using stimulus control and reinforcement management strategies.

Stage 3: Comprehensive Approach to Behaviour Change

If sustained health behaviour is the goal of health care interventions, the whole person/holistic view of the patient must be considered including physical health, emotional health, spiritual health, and mental health. In supporting patients with chronic disease, it is often challenging to support behaviour change without considering the multiple components that encompass health. This program adopts a quality of life/functional health model when supporting patient behaviour change. This allows HCPs to differentiate between elements of health that can be supported within the chronic disease program or service area versus what aspects of health must be supported by partner programs. Mental health is an important component to chronic disease management and providers require skills in assessing chronic disease distress and well-being and differentiating between mental health needs that are grounded in psychopathology. Health care providers require knowledge of internal facilitators and external barriers to change and will develop skills in identifying needs, educating the patient, making recommendations, and supporting the patient in those recommendations. Skills will be attained in replacing the function of unhealthy behaviour and supporting emotional regulation and acceptance techniques. Health care providers will develop skills in supporting these challenging conversations with patients.

Table 1.0 – Foundations of Behaviour Change

Principle	Component	Behaviour Change Knowledge	Behaviour Change Skill	Definition
	Definitions of self-management and self-management support, PHC SMS model, BC Counselling Development Program	✓		
	Stage of readiness to engage in training	✓		Probably should be part of each stage
Stage 1: Foundations of Behaviour Change	Bond, task and goal alliance	✓		Recognizes three types of alliances between the patient and health care provider needed for a change-based relationship: bond (emotional), task (behaviour) and goal (outcome).
	Dangers of teach and tell	✓		Recognizes that the typical stance of a health care provider (e.g., to lecture, explain, talk) is insufficient for a change-based relationship. Sustained behaviour change in chronic disease management requires a more collaborative and empowering approach.
	Challenges with changing behaviour	✓		Recognizes that changing behaviour is hard and the recommendations health care providers often make are difficult to sustain.
	Ask, listen, summarize and invite		✓	Recognizes the importance of motivational communication/interviewing in sustained behaviour change.
	Non-judgmental curiosity, managing ambivalence, rolling with resistance		✓	Adopts an attitude consistent with motivational communication, which emphasizes being curious and empathic (non-judgmental curiosity), comfortable with contradictions (managing ambivalence), and comfortable with setbacks (rolling with resistance).

Table 2.0 – Building on Behaviour Change

Principle	Component	Behaviour Change Knowledge	Behaviour Change Skill	Definition
Stage 2: Building on Behaviour Change	Defining behaviour		✓	Recognizes the importance of identifying, clarifying and isolating specific behaviour(s) in supporting sustained behaviour change. There must be a shared understanding of the behaviour between patient and health care provider.
	Traffic light readiness assessment		✓	Readiness is a fluctuating state that represents the extent to which an individual is prepared for and committed to change
	Health beliefs	✓		Recognizes that readiness to change may be impacted by underlying health beliefs. Health beliefs represent the patient's understanding of disease and behaviour change.
	Decisional balance and working with ambivalence		✓	Using readiness to provide appropriate treatment/interventions. Decisional balance involves uncovering the pros and cons of health behaviour change. Ambivalence involves recognizing that we can hold contradictory positions (i.e., change can be both "good" and "bad").
	Maintaining the relationship		✓	Using readiness to provide appropriate treatment/interventions. Keeping a non-judgmental and engaged relationship with the patient who is not ready to change. The health care provider works to evoke ambivalence.
	Goal setting	✓	✓	Is the process of determining specific, measurable, achievable, relevant, and timely (SMART) goal(s) that are driven by the patient and in alignment with health behaviour change.
	Shaping	✓	✓	Is able to support change by breaking down larger goals into smaller, more achievable goals.
	Reinforcement management	✓	✓	Identifies and encourages the use of reinforcements (either positive or negative) to support sustained behaviour change.
	Stimulus control	✓	✓	Recognizes that behaviour is largely influenced by the environment. In some cases, the environment can be structured in a way to support sustained behaviour change.

Table 3 – Comprehensive Approach to Behaviour Change

Principle	Component	Behaviour Change Knowledge	Behaviour Change Skill	Definition
Stage 3: Comprehensive Approach to Behaviour Change	Quality of life model/functional health approach	✓		Recognizes that behaviour change is in support of enhancing the quality of life for the patient and improving function. In supporting sustained behaviour change, a holistic view must be taken.
	Distress/well-being assessment	✓	✓	Recognizes that distress may be related to disease-based distress, problems of living distress (i.e. social determinants of health) or psychopathology. Health care providers can assess for chronic disease distress/well-being (within their scope of practice) and refer to other services/health care providers as part of the circle of care.
	Self-image, self-efficacy, social support and stress management (4 S's)	✓	✓	In order to achieve sustained behaviour change, behaviour must be linked to a patient's self-image. Self-efficacy is the patient's confidence to perform a specific behaviour in a specific context, for a specific period of time in the face of specific barriers. Social support may act as a barrier or enabler in supporting behaviour change. Stress impacts a patient's ability to engage in self-care activities required for successful behaviour change.
	Identify, educate, recommend and support		✓	A facilitation approach that health care providers can use to support patients in navigating their psychosocial needs within their scope of practice.
	Replacing the function		✓	Recognizes that behaviours (e.g., "unhealthy" health behaviours) serve a function. Behaviour change can be supported by identifying the function of an "unhealthy" behaviour and replacing it with an alternative that is more consistent with long term health.
	Emotional regulation and emotional acceptance techniques		✓	Recognizes that patients often know what they "should be doing" but emotions can interfere with these goals. Emotional regulation and emotional acceptance techniques

Appendix G

Example of Pre-Test Survey, E-Module 1

To be administered before participant begins the first module

Survey Page 1 Title Page

Survey Title: Foundations of Behaviour Change Pre-Survey

Thank you for taking the time to complete e-modules about self-management support for patients. The first step in the process is to complete this brief pre-module assessment, which helps us determine the knowledge level of participants before they begin the module. It is quite possible that you will not know the answers to some of the questions in this assessment, which is fine. Please just select the "don't know" option rather than guessing answers if you are unsure.

After you have completed this survey, click the "x" in the window at the top right-hand corner of your screen and you will be returned to the e-module.

Note for evaluators; do not include this box in survey: knowledge assessment questions below map to evaluation question 2.1 in evaluation framework and knowledge competencies

Survey Page 2:

1. Is this your first time reviewing Foundations of Behaviour Change E-modules?
    - Yes
    - No

Survey Page 2

2. What zone do you work in? (set up with *drop down boxes*)
    - Central Zone
    - Eastern Zone
    - Northern Zone
    - Western Zone

3. What is your current job title? (set up with *drop down boxes in alphabetical order*)
    - Coordinator
    - Counsellor
    - Dietitian
    - Director
    - Family Physician
    - Health Services Lead

- Health Services Manager
- LPN
- Nurse Practitioner
- Occupational Therapist
- Physiotherapist
- Psychiatrist
- Psychologist
- RN
- Social Worker
- Wellness Navigator
- Wellness Facilitator
- Other (*please specify)*

4. What is your primary practice or work setting?

    - Administrative Setting
    - Chronic Disease Team
    - Chronic Disease/Wellness Team
    - Collaborative Family Practice Team
    - Diabetes Team
    - Group Family Practice
    - Solo practitioner
    - Wellness Team
    - Other (*free text*)

Survey Page 3 *(set up as 5-point Likert scale where 1= strongly disagree, 2=disagree, 3= neutral, 4= agree and 5 = strongly agree; set requirement that all questions must be answered)*

Page Title: The following questions pertain to behaviour change counselling knowledge and skills.

5. To what extent do you agree with the following statements:

    - I believe I can benefit from training in behavioural change counselling.
    - I believe my patients would benefit if I had additional training in behavioural change counselling.
    - I feel hopeful that I would be able to improve my practice after the behavioural change counselling
    - I have a good understanding of how my practice will benefit after I participate in behavioural change counselling training.
    - I believe my organization has or will provide me with the resources I need to complete the training (e.g., time, study materials)
    - I believe I will be supported by my organization and colleagues to implement changes in my practice based on what I learn through the behavioural change counselling program.
    - I have a way to measure the impact of any changes in my practice that happen as a result of behavioural change counselling.

Survey Page 4

6. The PHC Self-Management Support Model includes the following components: (check all that apply):

    - **The person has the knowledge, skills, and confidence to be the driver of their own health and wellness**
    - Health care providers have the knowledge, skills, and confidence to drive their patient's health and wellness
    - **Organizational support for self-management**
    - **Wider system support for self-management**
    - **Informed and skilled health care providers**
    - All of the above
    - None of the above
    - Don't know

Survey Page 5

7. Behaviour Change Counselling is a skillset that(check all that apply):

    - **All health care providers should use in daily practice**
    - Only certain health care providers, such as psychologists or social workers, can use
    - Is easy to learn and do
    - **Requires training and practice**
    - **Is evidence-based**
    - Doesn't work well because most people aren't willing to work hard
    - All of the above
    - None of the above
    - Don't know

Survey Page 6

8. Which of the following are elements of motivational communication? (check all that apply):

    - **Non-judgmental curiosity**
    - Mobilizing knowledge
    - **Managing ambivalence**
    - Assessment and evaluation
    - **Rolling with resistance**
    - All of the above
    - None of the above
    - Don't know

Survey Page 7

9. What are the different alliances needed between the patient and health care provider for a change-based relationship? (check all that apply):
    - Objective
    - **Goal**
    - **Bond**
    - **Task**
    - Therapeutic
    - Rolling with resistance
    - All of the above
    - None of the above
    - Don't know

Survey Page 8

10. What are the main reasons that patients find change hard to sustain (check all that apply):
    - **Choosing healthy behavior requires us to overcome human physiology and our modern environment**
    - **Health care providers expect their patients to make changes that are important to themselves and not to their patient.**
    - **In our society, healthy behavior is abnormal**
    - **Humans are designed to seek pleasure, avoid pain, follow the path of least resistance, and live for the moment**
    - People are often not willing to work hard enough
    - **They want to please the health care provider instead of working on something that is important to them**
    - People have low motivation to make changes
    - All of the above
    - None of the above
    - Don't know

Note for evaluators; do not include in survey: skill assessment questions follow (maps to evaluation question 2.2 and skill competencies)

Survey Page 9

11. Asking questions: (check all that apply)

- Is the first step to motivational communication
- Makes the patient feel like you care about their perspective, agenda, and goals
- Should be framed as open-ended questions
- Should involve asking permission to give advice, suggestions, or information
- Is a key ingredient of establishing a change-based relationship
- **All of the above**
- None of the above
- Don't know

Survey Page 10

12. Some examples of questions you could ask to establish a change-based relationship are: (check all that apply)

- **Why is this important to you?**
- **What's your first step?**
- **Do you want to do this or that?**
- **What are you willing to change today?**
- Can you hurry up?
- All of the above
- None of the above
- Don't know

Survey Page 11

13. When you are doing most of the talking when meeting with a patient, you are NOT demonstrating the following skill (check all that apply):

- **Listening**
- Compassion
- Empathy
- Nonjudgmental curiosity
- All of the above
- None of the above

Survey Page 12

14. "You are not sure you will be able to participate in the exercise class, so you are reluctant to try it" is an example of which motivational communication skill (check all that apply):

- Asking open questions

- **Reflective listening**
- Information-giving
- None of the above
- All of the above

Survey Page 13

15. Inviting is(check all that apply):
    - **About linking your understanding of what the patient says to the recommendations you want to give**
    - **Pausing and waiting for the patient to respond**
    - **Not providing advice if the patient is not ready for it**
    - **Not always a smooth transition**
    - Not needed because your patient will know you are listening if you summarize
    - All of the above
    - None of the above

Survey Page 14

16. Non -judgmental curiosity(check all that apply):
    - Involves being curious and holding our judgements at bay
    - Helps us to understand patient behaviours through the lens of the patient
    - Realizes that people do “bad” behaviours for “good” reasons
    - Helps you to uncover why the behaviour “works” for the patient
    - **All of the above**
    - None of the above

Survey Page 15

17. “I can’t believe that woman is smoking while pregnant….” is an example of(check all that apply):
    - Assessing the situation
    - Understanding why people do certain behaviours
    - **Judgment**
    - Your opinion of an unhealthy behaviour that will cause harm
    - All of the above
    - None of the above

Survey Page 16

18. Which of the following statements is NOT recommended as part of information giving within the context of motivational communication(check all that apply)?

    - Asking permission to give information
    - **Telling patients everything they need to know about their treatment**
    - Providing facts rather than opinions
    - Asking patients for feedback
    - None of the above

Survey Page 17

19. "I don't want to try a new medication because I am afraid of the side effects" is an example of(check all that apply):

    - Change-talk
    - Confidence
    - Sustain-talk
    - **Ambivalence**
    - None of the above
    - All of the above

Thank you for taking the time to complete the survey.

Appendix H

Example of Virtual Workshop Survey

To be administered immediately after participant completes any virtual workshop.

Note: For select survey, all questions are required except question 9

Survey Page 1 Title Page

Survey Title: Behaviour Change Counselling Development Program – Virtual Workshop Survey

Thank you for participating in the virtual workshop. Please complete the following brief survey. Your answers will help us continually improve the program over time.

Survey Page 2:

2. What zone do you work in? (set up with *drop down boxes*)
    - Central Zone
    - Eastern Zone
    - Northern Zone
    - Western Zone

3. What is your current job title? (set up with *drop down boxes in alphabetical order*)
    - Physiotherapist
    - Occupational Therapist
    - Dietitian
    - Social Worker
    - Counsellor
    - Wellness Navigator
    - Wellness Facilitator
    - RN
    - LPN
    - Nurse Practitioner
    - Family Physician
    - Psychologist
    - Psychiatrist
    - Health Services Manager
    - Health Services Lead
    - Director
    - Coordinator
    - Other (*please specify)*

4. What is your primary practice or work setting?

- Collaborative Family Practice Team
- Group Family Practice
- Solo practitioner
- Chronic Disease Team
- Wellness Team
- Chronic Disease/Wellness Team
- Administrative Setting
- Other (*free text*)

Survey Page 3

5. Which e-modules have you completed (please select one) (*buttons*)?
    - Foundations of Behaviour Change
        i. M1
        ii. M2
        iii. M3
        iv. M4
    - Building on Behaviour Change
        i. M1
        ii. M2
    - Comprehensive Approach to Behaviour Change
        i. M1
        ii. M2

6. How many virtual workshops have you participated in (please select one)(*buttons*)?
    - 1-3
    - 4-6
    - 7-12

Survey Page 4

7. To what extent have you been practicing or using the following behaviour change counselling skills in your practice **(add specific workshop skills**)? *(Set up as 5-point Likert scale where 1=never, 2=not very often, 3=most of the time, 4=always)*
    - Asking questions of patients in a way that supports behavioural change
    - Listening to patients in a way that supports behavioural change
    - Summarizing for patients in a way that supports behavioural change
    - Inviting in a way that supports behavioural change

8. Please rate your confidence in the following (**add specific workshop skills**) *(set up as 4-point Likert scale where 1=not at all confident, 2=not very confident, 3=somewhat confident and 4= very confident):*
    - Asking questions of patients in a way that supports behavioural change
    - Listening to patients in a way that supports behavioural change
    - Summarizing for patients in a way that supports behavioural change
    - Inviting in a way that supports behavioural change

Survey Page 5

9. To what extent do you agree with the following questions *(set up as 5-point Likert scale where 1=strongly disagree, 2=disagree, 3=neutral, 4=agree and 5=strongly agree)*

- The learning objectives for this workshop were met.
- Information learned in this workshop will be useful in my practice.
- I would recommend this workshop to my colleagues.
- The structure and format of the workshop was beneficial to my learning process.
- In this workshop I have been challenged to learn more than I expected.

Survey Page 6

10. Do you have any suggestions about how we could improve the Behaviour Change Counselling Development Program? <insert comment box for text response>

Appendix I

Interview Guide

Interview Guide

Leaders Involved in the Implementation of the Behaviour Change Counselling Development Program in PHC

Name and Job Title of Respondent: _____

Unique ID: _____

Zone: _____

Date of Interview: _____

Interviewer: _____

PURPOSE OF THE INTERVIEW

The purpose of this interview is to gather the perspectives of PHC leadership who have facilitated the implementation of the Behaviour Change Counselling Development Program over the past 18 months. Leaders may or may not have participated in the training components. The interviews are one aspect of the overall evaluation of the Behaviour Change Counselling Development Program.

Script for the interviewer is in *italics;* questions are in normal text.

INTRODUCTION AND CONSENT

Thank you for agreeing to participate in this interview to support the evaluation of the Behaviour Change Counselling Development Program in Primary Health Care. Participation in the interview is voluntary, and your answers will not be associated with your name in any reports that are written. We might use direct quotes from some of the people we interview, but we will not link the quotes to anyone's name. Hearing about your experiences in either supporting or participating in this training program will help us continue to figure out the best ways to continue supporting providers to improve their confidence and competence in behaviour change counselling.

Do you have any questions about the interview process? [answer questions]

To help with the analysis of the data from this interview, I would like to audio record our conversation and write notes as well. Do you give your permission for me to record the interview in this way? [if yes, proceed with next step; if no, discuss with interviewee an approach to recording their responses that makes them comfortable]

Thank you, I am going to start the audio recording now and ask you for your consent to participate in the interview, as well as your consent to record our conversation. Is that, OK?

Do you consent to participate in the interviews?

___Yes ___No – thank the interviewee and terminate the interview if the response is no.

Do I have your permission to audio record this interview?

___Yes ___No - If no, seek consent to take notes if permission to record is not given, and document on notes that audio recording consent was not given.

INTERVIEW

As a reminder, the components of the Behaviour Change Counselling Development Program include:

- *8 self-directed e-modules launched October 2020*
- *12 virtual workshops offered twice monthly. A repeat session was offered once/month for a period of time as well.*
- *Opportunities for staff and leaders to connect with behaviour change facilitators (Sarah Manley and Jacklynn Humphrey) to troubleshoot, coaching etc.*
- *Online resources available to all staff on Sharepoint.*
- *All training opportunities are optional. E-modules 1-4 (Foundations of Behaviour Change series are strongly recommended for all staff to complete, including leadership team members. PHC has set a goal of having at least 50% of staff complete these modules by the next Accreditation cycle – Fall 2022).*

Do you have any questions about this?

Let's begin. Use the questions to build the conversation. Do not need to say them verbatim. Scribe is off camera. Scribe will record. Take your lead from your interviewee as to if you go on camera or not.

1. How have you been involved in supporting PHC staff to participate in the Behaviour Change Counselling Development Program?
2. Have you participated in any aspects of the program? If so, what aspects? If not, why not?
3. What have been some of the facilitators in promoting the program with PHC team members?
4. What have been some of the barriers in promoting the program with PHC team members?
5. What are your overall impressions of the behaviour change counselling approach in relation to self-management support and the value of this approach in PHC? "What is your overall impression of this program and the value to PHC?"{Maps to indicator 1.8}
6. While the program is targeted for frontline providers, do you see value in PHC leadership team members participating in the program? {Maps to indicator 1.9}
    - If so, what components? Do you have any advice about this?
    - If not, why? Do you have any advice about this?
7. Do you feel health care providers working in your area are changing their practice as a result of participating in the program? {Maps to indicator 3.1}
    - If yes, can you describe some things you have observed as changing as result of providers participating in the program (i.e., incorporating material into assessment forms, team-based practice sessions, integration into patient education materials)
    - If no, can you tell me more about why?
8. What supports do formal leaders need to support health care providers to participate in training opportunities, practice and to integrate skills into workflows?
9. Do you have any ideas about how we could enhance the effectiveness of the program?
10. As we think about the future of this program, what do you think is necessary to support the ongoing effective use of behaviour change counselling in PHC?

Finally, to wrap up our discussion . . .

11. Do you have any other information about the Behaviour Change Counselling Development Program that you would like to share in support of the evaluation?

Thank you for your time. We will be sharing the results of the overall evaluation once we have analyzed and compiled the data.

Appendix J

Staff Survey

Primary Health Care Staff Survey:

Behaviour Change Counselling Development Program

Purpose of the Survey

The purpose of this survey is to gather the perspectives of Primary Health Care Providers, formal leaders, and administrative staff who have participated in the implementation of the Behaviour Change Counselling Development Program over the past 2 years. We are also looking to understand why some people may not have participated in the program. The survey is one aspect of the overall evaluation of the Behaviour Change Counselling Development Program.

Estimated time commitment to fill out this survey: 5 to 10 minutes.

Intended Audience

ALL PHC staff, including health care providers, formal leaders, and administrative staff, REGARDLESS of whether you have participated in the program.

Introduction and Consent

Thank you for agreeing to participate in this survey to support the evaluation of the Behaviour Change Counselling Development Program in Primary Health Care. Participation in the survey is voluntary, and your answers will not be associated with your name in any reports that are written. We might use direct quotes from some of the people we survey, but we will not link the quotes to anyone's name. We are going to use the information we receive from you and other surveyees for two purposes. First, understanding your experiences in either supporting or participating in this training program will help us continue to figure out the best ways to continue supporting providers to improve their confidence and competence in behaviour change counselling. Second, we plan to use what we see in the surveys to help us determine why some staff did not participate in the program to help us better understand the barriers and considerations from their perspectives.

By submitting the survey, you consent to participate.

Survey

As a reminder, the components of the Behaviour Change Counselling Development Program include:

- *8 self-directed e-modules launched in October 2020*
- *12 virtual workshops offered twice monthly. A repeat session was offered once/month for a period of time, as well.*
- *Opportunities for staff and leaders to connect with behaviour change facilitators (Sarah Manley and Jacklynn Humphrey) to troubleshoot, coaching etc.*
- *Online resources available to all staff on Sharepoint.*
- *All training opportunities are optional. E-modules 1-4 (Foundations of Behaviour Change series are strongly recommended for all staff to complete, including leadership team members. PHC has set a goal of having at least 50% of staff complete these modules by the next Accreditation cycle – Fall 2022).*

Throughout the survey, references to "the program" refer to the Behaviour Change Counselling Development Program. You may not see all survey questions, depending on your responses.

Role

a. Primary Health Care Provider
b. PHC Leadership
c. Administrative staff
d. Other – Please list your title if not covered in the categories above.

Zone

a. Central
b. Western
c. Eastern
d. Northern
e. Provincial

Date of Survey:

1) Have you accessed or participated in any of the program resources/components so far? Resources include LMS e-modules, Sharepoint site resources, Virtual workshops, Virtual Coaching.
    a. Yes
    b. No

2) Did you complete any of the E-modules?
    a. Yes
    b. No

    If you answered 'Yes' to Question 2, which modules did you complete? Check all that apply.

    a. PHC Foundations of Behaviour Change – Module 1: Introduction and Theory
    b. PHC Foundations of Behaviour Change – Module 2: Ask, Listen, Summarize, Invite PHC Foundations of Behaviour Change –
    c. Module 3: Non-Judgmental Curiosity
    d. PHC Foundations of Behaviour Change –Module 4: Motivational Argument, Ambivalence, Resistance
    e. PHC Building on Behaviour Change – Module 1: Define Behaviour, Readiness Assessments
    f. PHC Building on Behaviour Change – Module 2: Behaviour Modification
    g. PHC Comprehensive Approach to Behaviour Change – Module 1: Distress, Well-being, 4S's
    h. PHC Comprehensive Approach to Behaviour Change – Module 2: Replacing the Function, Stress Reduction
    i. Cannot remember but would like to know – Please provide your name

    If you answered 'No' to question 2, why didn't you participate in the e-modules? Check all that apply.

    a. Lack of time
    b. Redundant materials
    c. Not relevant to my practice
    d. Lack of leadership support to participate

e. Other - Please describe any other reason not listed above.

3) Did you participate in any Zoom virtual workshops?
   a. Yes
   b. No

If you answered Yes to question #3, which virtual workshops have you participated in? Check all that apply.

a. 1 – Ask, Listen, Summarize, Invite
b. 2 – Non-judgmental Curiosity
c. 3 – Motivational Argument, Ambivalence, Rolling with Resistance
d. 4 – Defining Behaviour
e. 5 – Readiness Assessment
f. 6 – Working with Green Lights: Goal Setting
g. 7 – Working with Yellow Lights
h. 8 – Working with Red Lights
i. 9 – Sustaining the Change: Shaping, Reinforcement Management, & Stimulus Control
j. 10 – Distress/ Well-being Assessment
k. 11 – The 4S's
l. 12 – Replacing the Function, Stress Reduction
m. Cannot remember but would like to know – Please provide your name

If you answered 'No' to question #3, why didn't you participate in the workshops?

a. Lack of time
b. Redundant materials
c. Not relevant to my practice
d. Lack of leadership support to participate
e. Other - Please describe any other reason not listed above.

4) Have you incorporated any of the knowledge or skills learned in the program into your daily work?
   a. Yes
   b. No

If you answer Yes to Question 4, what skills have you found most useful?

a. Ask, listen, summarize, and invite
b. Non-judgmental curiosity, managing ambivalence and rolling with resistance
c. Defining a behaviour
d. Traffic light readiness assessment
e. Goal setting and shaping
f. Decisional balance and working with ambivalence
g. Taking change off the table and maintaining the relationship
h. Reinforcement management
i. Stimulus control
j. Distress/well-being assessment
k. Identify, educate, recommend, and support
l. The 4 S's (self-image, self-efficacy, social support, stress management)

m. Replacing the function
n. Stress reduction strategies (i.e., acceptance, physical/mental calming, physical discharge, emotional expression, social connection)

If you answered 'Yes' to Question 4, what things helped you to integrate these skills into your daily work?

a. Informal team training
b. Peer support
c. Opportunities to practice with teams
d. Opportunities to practice with patients
e. Program tools and resources
f. Leadership support to make it a priority
g. Integration into workflows (patient resources)
h. Other - Please describe any other facilitators not listed above.

If you answered 'No' to Question 4, what things made it hard for you to implement these skills into your daily work?

a. Not relevant to my practice
b. Worktime pressures
c. Lack of team training
d. Lack of peer support
e. Not enough opportunities to practice with teams
f. Not enough opportunities to practice with patients
g. Lack of program tools and resources
h. Lack of leadership support to make it a priority
i. Limited integration into workflows (patient resources)
j. Other - Please list other barriers not listed above.

5) What have been some of the enablers in participating in the program? Check all that apply.
   a. Ease of access to training, tools, and resources
   b. Organizational support
   c. Direct manager/lead support
   d. Dedicated time
   e. Range of modalities to access different parts of the program (LMS, Sharepoint, Virtual Workshop)
   f. Having LMS modules preassigned for providers
   g. Seeing others succeed, mentors or passionate providers/leaders that are using this successfully
   h. Other – Please list any additional facilitators.

6) What have been some of the barriers in participating in the program? Check all that apply.
   a. Lack of access to training, tools, and resources
   b. Lack of organizational support
   c. Lack of direct manager/lead support
   d. Lack of dedicated time
   e. Competing priorities
   f. Not important to my practice

g. Lack of visibility of success in other health care providers using skills; colleagues not seeing the value in using skills
h. Other – Please list any additional barriers.

7) What resources do you feel will support healthcare providers to integrate behaviour change counselling into their practice? Check all that apply.
   a. Dedicated person/champion in each zone to support the work
   b. Dedicated person/champion on individual team to support the work
   c. Documentation, standards, decision support tools
   d. Community of practice
   e. Dedicated time to practice and/or attend training
   f. No support needed
   g. Other – Please list any other resources not listed above.

8) In thinking about the program training opportunities, please rate the usefulness of the program components. (Where 1 is not useful and 5 is very useful)

   E-Modules

   a. 1 - Not Useful
   b. 2 - Somewhat Useful
   c. 3 - Neutral
   d. 4 - Useful
   e. 5 - Very Useful
   f. Did not access

   Handouts

   a. 1 - Not Useful
   b. 2 - Somewhat Useful
   c. 3 - Neutral
   d. 4 - Useful
   e. 5 - Very Useful
   f. Did not access

   Virtual Workshops

   a. 1 - Not Useful
   b. 2 - Somewhat Useful
   c. 3 - Neutral
   d. 4 - Useful
   e. 5 - Very Useful
   f. Did not access

   Opportunities to reach out for individual coaching

   a. 1 - Not Useful
   b. 2 - Somewhat Useful
   c. 3 - Neutral
   d. 4 - Useful

e. 5 - Very Useful
f. Did not access

9) On a Scale of 1 to 5, how satisfied are you with the care you provide patients as a result of participating in the program?
    a. 1 - Very Unsatisfied
    b. 2 - Unsatisfied
    c. 3 - Neutral
    d. 4 - Satisfied
    e. 5 - Very Satisfied
    f. N/A (I don't do direct patient care)

10) In thinking about all the skills you have learned, where would you place yourself on the learning continuum? (Pick the response that best reflects your behaviour change skills) (Where 1 is not competent at all and 5 is very competent)

    Awareness

    - Some understanding of the knowledge and skills of behaviour change counselling
    - Starting to incorporate some skills into practice

    a. 1 - Not Competent at all
    b. 2 - Somewhat Competent
    c. 3 - Neutral
    d. 4 - Competent
    e. 5 - Very Competent

    Competency

    - Sufficient knowledge and skills of behaviour change counselling
    - Able to integrate more than one skill into practice

    a. 1 - Not Competent at all
    b. 2 - Somewhat Competent
    c. 3 - Neutral
    d. 4 - Competent
    e. 5 - Very Competent

    Confidence

    - Fulsome knowledge and skills of behaviour change counselling.
    - Ability to integrate many skills into many different practice scenarios

    a. 1 - Not Competent at all
    b. 2 - Somewhat Competent
    c. 3 - Neutral
    d. 4 - Competent
    e. 5 - Very Competent

    Creativity

    - Enhanced knowledge and skills of behaviour change counselling.
    - Ability to integrate all skills into any practice scenario

a. 1 - Not Competent at all
b. 2 - Somewhat Competent
c. 3 - Neutral
d. 4 - Competent
e. 5 - Very Competent

11) On a scale of 1-5, how likely are you to continue using behaviour change counselling in your practice?
    a. 1 - Very Unlikely
    b. 2 - Unlikely
    c. 3 – Neutral - If yes, how will you do that?
    d. 4 – Likely - If yes, how will you do that?
    e. 5 - Very Likely - If yes, how will you do that?

12) What are the best ways to promote this program to PHC staff?
    a. Word of mouth
    b. Directly from supervisor/manager
    c. Emails
    d. Posters
    e. Presentations
    f. Existing meetings
    g. Through existing Communities of Practice
    h. Other – Please mention any other ways to promote to PHC staff

13) On a Scale of 1 to 5, how useful do you think a Community of Practice would be to support the ongoing capacity building of the Behaviour Change Counseling Program? (Where 1 is not useful at all and 5 is very useful)
    a. 1
    b. 2
    c. 3
    d. 4
    e. 5

    In what ways would you see a Community of Practice being useful? Check all that apply.

    a. Build and strengthen peer leaders' knowledge and skills,
    b. Promote the uptake of this skillset with leaders, colleagues, and health care providers
    c. Create a shared repertoire of resources (experiences, stories, tools, materials, and ways of addressing recurring barriers/problems).
    d. Other – Please mention any other benefits not listed above.

    What format of Community Practice would be most useful? Check all that apply.

    a. Online sharing and discussion platform
    b. Virtual meetings to discuss, share and troubleshoot case scenarios, practice skills etc
    c. Virtual training opportunities for peer leaders to build knowledge and skills Joining existing communities of practice
    d. Handouts and tools

e. All of the above
f. Other – Please list any other format not listed above.

If you do not think a Community of Practice would be useful, why not? Check all that apply.

a. Too many communities of practice already exist
b. Not interested in participating
c. No time to participate
d. Other – Please mention any other reason not listed above.

14) Given that leadership support is a key enabler to promoting the uptake of behaviour change counselling in clinical practice, on a scale of 1 to 5, should the program be required (I.e., not optional) for PHC leadership? (Where 1 is not required and 5 is strongly required)
    a. 1
    b. 2
    c. 3
    d. 4
    e. 5

Of the modules listed below, which ones should be required for PHC leaders? Check all that apply.

a. PHC Foundations of Behaviour Change – Module 1: Introduction and Theory
b. PHC Foundations of Behaviour Change – Module 2: Ask, Listen, Summarize, Invite
c. PHC Foundations of Behaviour Change – Module 3: Non-Judgmental Curiosity
d. PHC Foundations of Behaviour Change – Module 4: Motivational Argument, Ambivalence, Resistance
e. PHC Building on Behaviour Change – Module 1: Define Behaviour, Readiness Assessments
f. PHC Building on Behaviour Change – Module 2: Behaviour Modification
g. PHC Comprehensive Approach to Behaviour Change – Module 1: Distress, Well-being, 4S's
h. PHC Comprehensive Approach to Behaviour Change – Module 2: Replacing the Function, Stress Reduction
i. All of the above
j. None of the above

15) On a scale of 1 to 5, should the program be required (not optional) for all health care providers? (1 is not required and 5 is strongly required)
    a. 1
    b. 2
    c. 3
    d. 4
    e. 5

Of the modules listed below, which ones should be required for healthcare providers? Check all that apply.

a. PHC Foundations of Behaviour Change – Module 1: Introduction and Theory
b. PHC Foundations of Behaviour Change – Module 2: Ask, Listen, Summarize, Invite

c. PHC Foundations of Behaviour Change – Module 3: Non-Judgmental Curiosity
d. PHC Foundations of Behaviour Change – Module 4: Motivational Argument, Ambivalence, Resistance
e. PHC Building on Behaviour Change – Module 1: Define Behaviour, Readiness Assessments
f. PHC Building on Behaviour Change – Module 2: Behaviour Modification
g. PHC Comprehensive Approach to Behaviour Change – Module 1: Distress, Well-being, 4S's
h. PHC Comprehensive Approach to Behaviour Change – Module 2: Replacing the Function, Stress Reduction
i. All of the above
j. None of the above

16) On a scale of 1 to 5, should the program be required (not optional) for administrative staff? (1 is not required and 5 is strongly required)
    a. 1
    b. 2
    c. 3
    d. 4
    e. 5

    Of the modules listed below, which ones should be required for administrative staff?

    a. PHC Foundations of Behaviour Change – Module 1: Introduction and Theory
    b. PHC Foundations of Behaviour Change – Module 2: Ask, Listen, Summarize, Invite
    c. PHC Foundations of Behaviour Change – Module 3: Non-Judgmental Curiosity
    d. PHC Foundations of Behaviour Change – Module 4: Motivational Argument, Ambivalence, Resistance
    e. PHC Building on Behaviour Change – Module 1: Define Behaviour, Readiness Assessments
    f. PHC Building on Behaviour Change – Module 2: Behaviour Modification
    g. PHC Comprehensive Approach to Behaviour Change – Module 1: Distress, Well-being, 4S's
    h. PHC Comprehensive Approach to Behaviour Change – Module 2: Replacing the Function, Stress Reduction
    i. All of the above
    j. None of the above

17) Do you have any ideas about how we could enhance the effectiveness of program?

If you would like to participate in a Community of Practice or share your participant testimonial, please email PHCPracticeSupport@nshealth.ca.

Thank you for your participation in the survey!

Appendix K

Open Text Responses Summary

Continued use of behavior change counselling

Respondents who selected neutral or above when asked about the likelihood of continued use of behavior change counselling in their practice were then prompted to explain how they would continue to use the programs skills in their everyday practice. Many respondents explained how they would continuously reflect on what they had learned and work to implement it into their daily work. One respondent said, “I will be a better communicator, using non-judgmental curiosity, managing ambivalence, and rolling with resistance”. Another respondent said I will “incorporate open ended questions, summarizing and goal setting” into my daily work. A final comment left by a survey respondent was I will use the program skills in “how I counsel patients, including how I question them by using open ended question. I will focus more on their own goals”. Another commonly mentioned means of continued ways was through direct patient care, including “providing patients with handouts” and “giving participants time to fill out resource sheets during appointments, then have a discussion”. Finally, many respondents said that they would continue to use the program skills in everyday practice by “revisiting the information annually” and “accessing more education as it becomes available in order to learn more”.

Ideas to enhance the effectiveness of the program

Respondents provided many intriguing ideas regarding how to enhance the effectiveness of the behavior change counselling program. One of the most common recommendations was regarding timing. Respondents would like “more time to try scenarios”, would like prerecorded virtual support meetings as “current times conflict with dedicated patient care time” and would like to be given the dedicated time for “practices to learn together, otherwise it is mishmash of people who have or haven’t done it”. Additionally, many respondents suggested that “sharing positive outcome stories from providers who have implemented program skills” is important when attempting to enhance the program. This may be done by a “clinical champion in each zone who can lead the discussion at the community of practice” and by “more buy-in from leadership”. Also, the tailoring of the program to target different, specific audiences was mentioned as an idea to enhance the effectiveness of the program. A respondent said “for example, for non-providers, use examples that demonstrate how the principles apply within the context of the workplace or one's own life. Within the context of a provider-patient relationship, it is appropriate for the provider to help the patient to change an undesirable behavior, but how would this concept translate to the workplace. The relationships are very different in that your colleagues might not be looking to you to help them change their behavior. Similarly, for people who might want to change their own behavior - how do you apply the concept of non-judgmental curiosity outside of a dyad?”. Finally, in order to enhance the effectiveness of the program, respondents suggested “clarifying the differences between tools, such as the differences between the purpose of online tools and virtual meetings”.