



**Extending Prevention Through Peers:  
How Volunteer Peer Health Coaches and Prevention Practitioners Can  
Advance Equity in Chronic Disease and Cancer Prevention**

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Canadian  
Cancer  
Society



*Financial contribution:*



Public Health  
Agency of Canada

Agence de la santé  
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BETTER For All is a partnership of Canadian Cancer Society, Women's College Hospital and Access Alliance. The program is offered through the Mid-West Toronto Ontario Health Team and is made possible with funding the Public Health Agency of Canada.

# Land Acknowledgement

*With appreciation and respect, we are living and working on the traditional territory of many nations including the Mississaugas of the Credit, the Anishinabek, the Chippewa, the Haudenosaunee and the Wendat peoples. This land is now home to many diverse First Nations, Inuit and Métis peoples.*

*We are grateful to have the opportunity to gather, work and play on this land, and we acknowledge the enduring presence and deep traditional knowledge of Indigenous peoples with respect to this territory.*



# Meet the Panel



**Arionne Mitchell** (*she, her/elle*) MSc;  
Team Lead,  
Canadian Cancer Society



**Ezza Jalil** (*she, her/elle*), MPH;  
Research Assistant,  
Access Alliance



**Shebina Amlani** (*she, her/elle*),  
Senior Specialist,  
Canadian Cancer Society



**Karen Kuzmich** (*she, her/elle*), MPH;  
Manager,  
Canadian Cancer Society



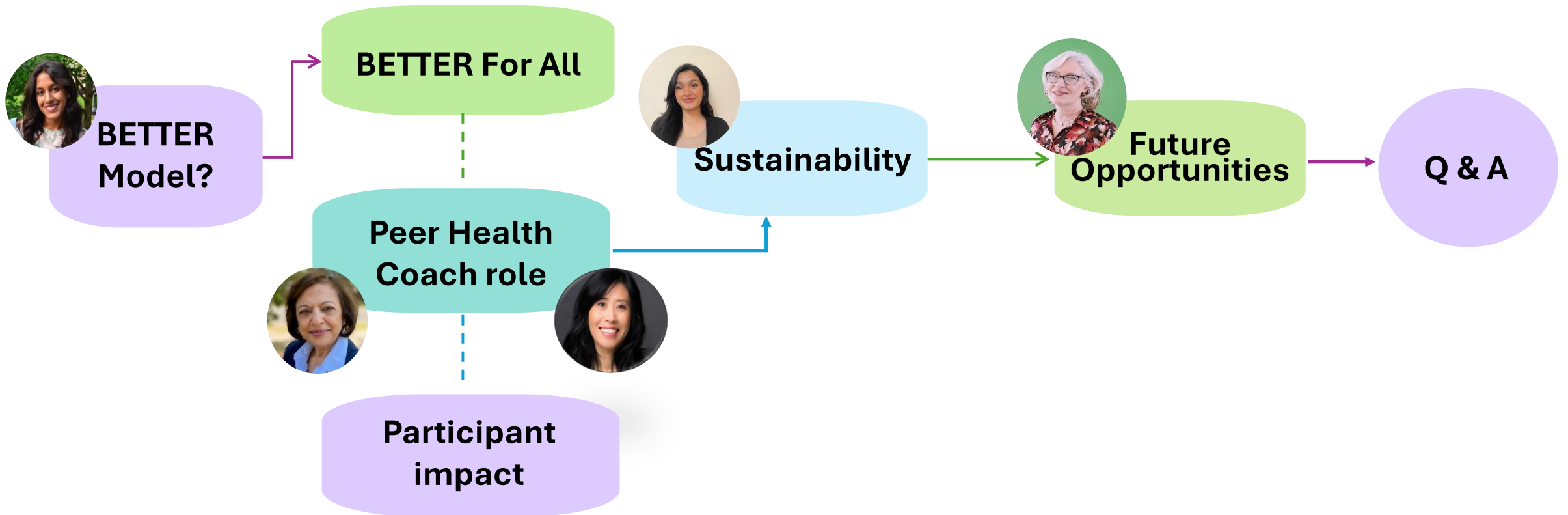
**Jean Eng** (*she, her/elle*),  
Peer Health Coach,  
BETTER For All Program

## Co-authors:

Lynn Murad (CCS); Akm Alamgir (AA); Jackie Bender,  
Dr. Aisha Lofters, Dr. Kimberly Devotta (WCH)



# Our Learning Journey



# The BETTER approach

 **BETTER.** *Building on Existing Tools to Improve Cancer and Chronic Disease Prevention and Screening in Primary Care*



**Est. 2011 in Canada.**  
Facilitated by **BETTER**  
**Institute till 2025**



Created by **primary care**  
**providers in primary**  
**care settings**



**Focus on prevention**  
**and screening of cancer,**  
diabetes, heart disease  
and key lifestyle factors



**Prevention**  
**Practitioner training**  
**for frontline providers**  
in prevention and  
screening **led by the**  
**BETTER Institute**



**Prevention visit**  
Emphasizes **shared**  
**decision-making,**  
**personalized** approach  
and **S.M.A.R.T.**  
**goal-setting** with  
patients

“BETTER is a unique program that has developed an approach that has been tested and proven through rigorous trial methodology to integrate prevention and screening for major chronic diseases through Prevention Practitioners”

Dr. Eva Grunfeld



# BETTER Tools

Date completed:  
 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (month) (day) (year)

## BETTER Health Survey First Visit

Thank you for completing the BETTER Health Survey!

Your answers will help us provide better care for you.

During the visit, you and your healthcare provider will talk about how you can improve your health and the screening tests recommended for you. You will be able to set your own health goals and create a plan to help you achieve them.

Later, your healthcare provider will check with you to review your progress, help you change your plan, if needed, and set new goals.

**INSTRUCTIONS:** Please answer all questions as best you can.

For each question, please circle the number that matches your answer or fill in the blank as needed.

Your answers will help your healthcare provider get ready for your Prevention visit.

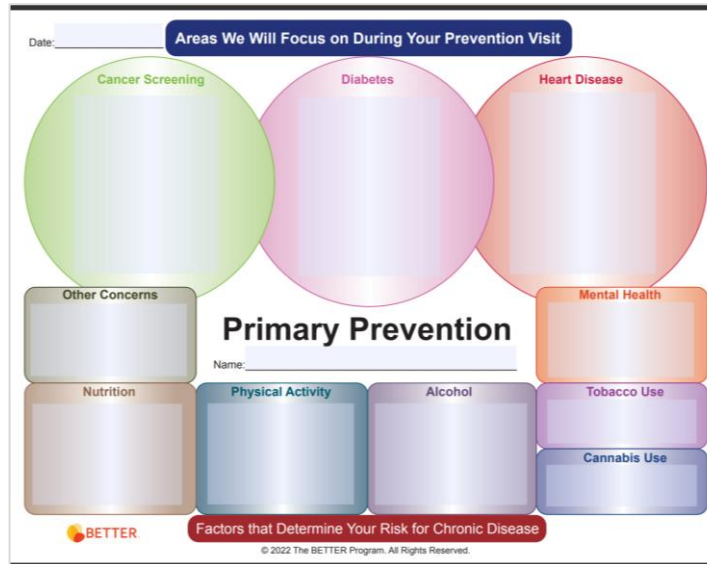
You are free to refuse to answer any question you wish.

If you wish to make a comment on any of the questions, please use the space at the end of the survey.

*You may complete your survey and return it to your healthcare provider, or complete the survey with your healthcare provider.*



## 1. BETTER Health Intake Survey



## 2. Bubble diagram

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID Number: \_\_\_\_\_

	1	2	3	4	5	6	7
	WAYS I CAN IMPROVE MY HEALTH - WHAT? (Set Your Goal)	HOW MUCH?	HOW OFTEN?	WHEN?	WHERE?	CHECK IN Who? When? How?	RATE YOUR CONFIDENCE (Choose One per Goal)
Goal #1							0 - Not at all confident 1 2 3 - A little confident 4 5 - Somewhat confident 6 7 8 - Very confident 9 10 - Totally confident
Goal #2							0 - Not at all confident 1 2 3 - A little confident 4 5 - Somewhat confident 6 7 8 - Very confident 9 10 - Totally confident
Goal #3							0 - Not at all confident 1 2 3 - A little confident 4 5 - Somewhat confident 6 7 8 - Very confident 9 10 - Totally confident

## 3. Goal Setting sheet

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name: \_\_\_\_\_

**THE BETTER PROGRAM**  
 Your Health Care Team and You Working Together:  
**THE PREVENTION PRESCRIPTION**

At your visit, we worked together to identify a number of important actions you can take to help prevent chronic disease. This tool can be used to increase your understanding of the recommended guidelines for regular screening around some of the following potential lifestyle concerns and chronic diseases. Together, we can take steps to support and improve your health and well-being!

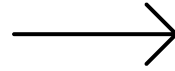
Screening For:	Status/Results	Target	Re-Check	Referrals/Actions
<b>Cardiovascular Disease</b>	Enter measurement value or lab value		Enter year or time frame	Enter referrals made or action items for patient or clinician
BMI	kg/m <sup>2</sup>	18.5 – 24.9 kg/m <sup>2</sup>		
WC	cm	Males < 102 cm Females < 88cm		
Blood pressure	/	Diab < 130/80 Non-Diab < 140/90		
Risk Assessment	%	Every 3 years*		
ACE/ARB Rec.				
<b>Diabetes</b>	FBS mmol/L or HbA1c%		Enter year or time frame	Enter referrals made or action items for patient or clinician
FBS/HbA1c		FBS <6mmol/L HbA1c <6.0%		
<b>Cancer Screening</b>	Enter month and year of last test		Enter year or time frame	Enter referrals made or action items for patient or clinician
FOBT/FIT	/	Every 2 years*		
Sigmoidoscopy	/	Every 10 years*		
Colonoscopy	/	Every 10 years*		
Pap test	/	Every 3 years*		
Mammogram	/	Every 2 years*		
Lung	/			
<b>Lifestyle Concerns</b>			Enter year or time frame	Enter referrals made or action items for patient or clinician
Physical activity		≥ 150 mins/week, limit sedentary behaviour (sitting or lying down for long periods)		
Diet		Fruits & vegetables (7-10 servings/day), Low salt, Limit fat & sugar		
Alcohol		M ≤ 14 drinks/week F ≤ 7 drinks/week		
Smoking		Quit/Reduce		
Mental Health				

\*These are normal screening intervals. Review patient risk status to determine if they are at elevated risk.

**Patient has possible elevated risk for:**  
 1. Diabetes: Yes/No    2. Breast cancer: Yes/ No    3. Colorectal cancer: Yes/ No    4. Cardiovascular disease: Yes/No

Your next prevention appointment is in \_\_\_\_ months with:

## 4. Prevention Prescription



Multi-partnership randomized-control pilot program (2021-2024) pairing **women 40–69** from select sites with **Peer Health Coaches** for 6-month health-goal support

Multi-partnership program (2024-2027) pairing **adults 40-69, newcomers &/ from racialized communities** from CHCs and FHTs with **Peer Health Coaches** for 6-month health-goal support



# How does the BETTER For All program work?



## Prevention Practitioners

Practitioners are **trained in BETTER** prevention model at select CHC & FHT sites



## Peer Health Coach

**Volunteers** are trained by CCS to be Peer Health Coaches



## 6 Months of Support

**Peer Health Coaching Support** for up to 6 months

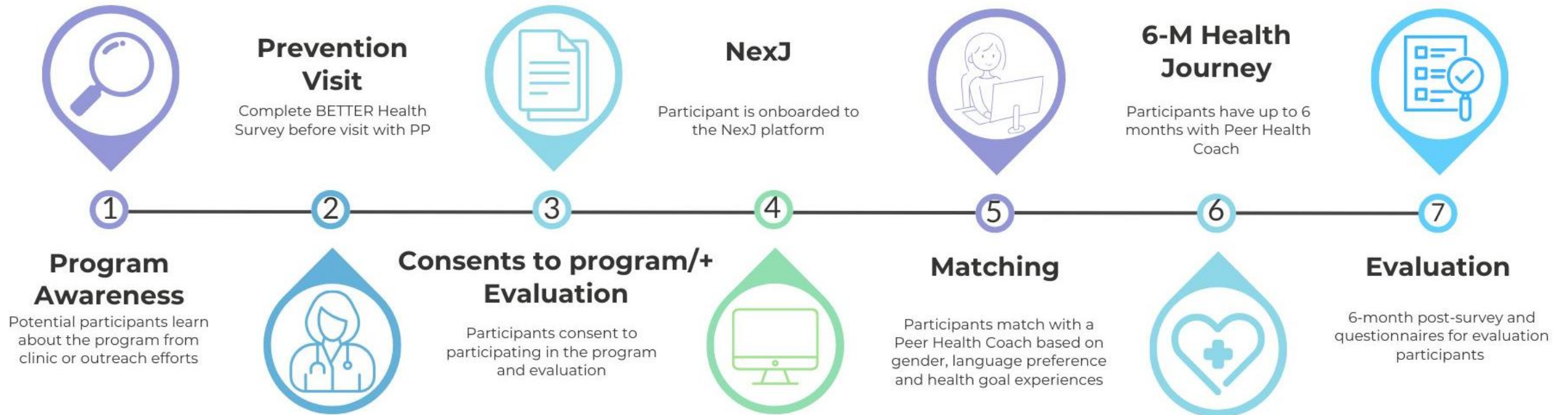


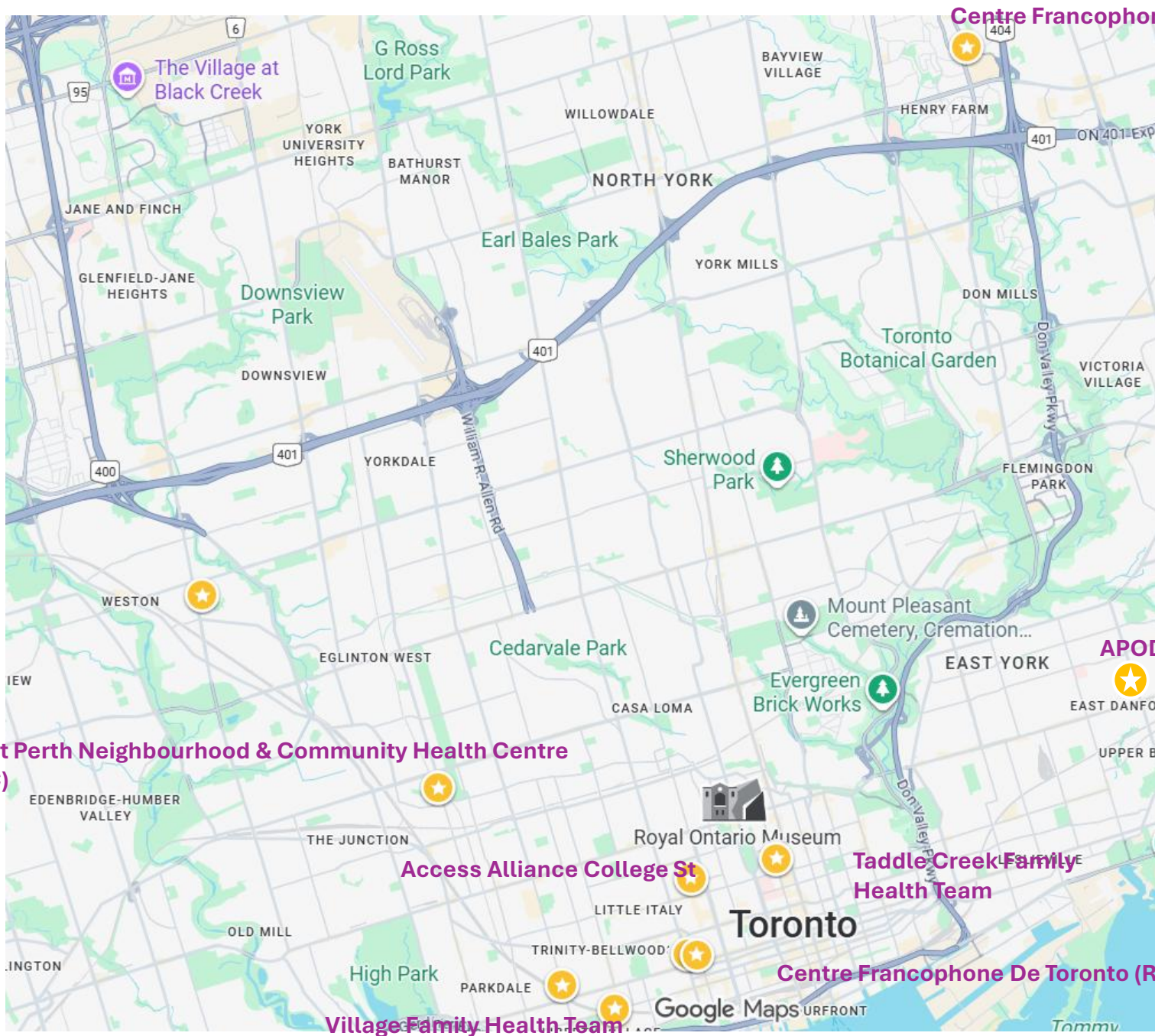
## Evaluation (optional)

**Pre- & post-surveys** with participants. Honorarium provided



# BFA Participant Journey





Centre Francophone du Grand (Fairview Mall)

Davenport Perth Neighbourhood & Community Health Centre (DPNCHC)

Village Family Health Team

Centre Francophone De Toronto (Richmond)

1. Access Alliance College
2. Access Alliance Danforth (APOD)
3. Village FHT
4. Access Alliance Jane
5. Davenport Perth Neighbourhood & CHC
6. Centre Francophone: Fairview Mall & Richmond
7. Taddle Creek FHT



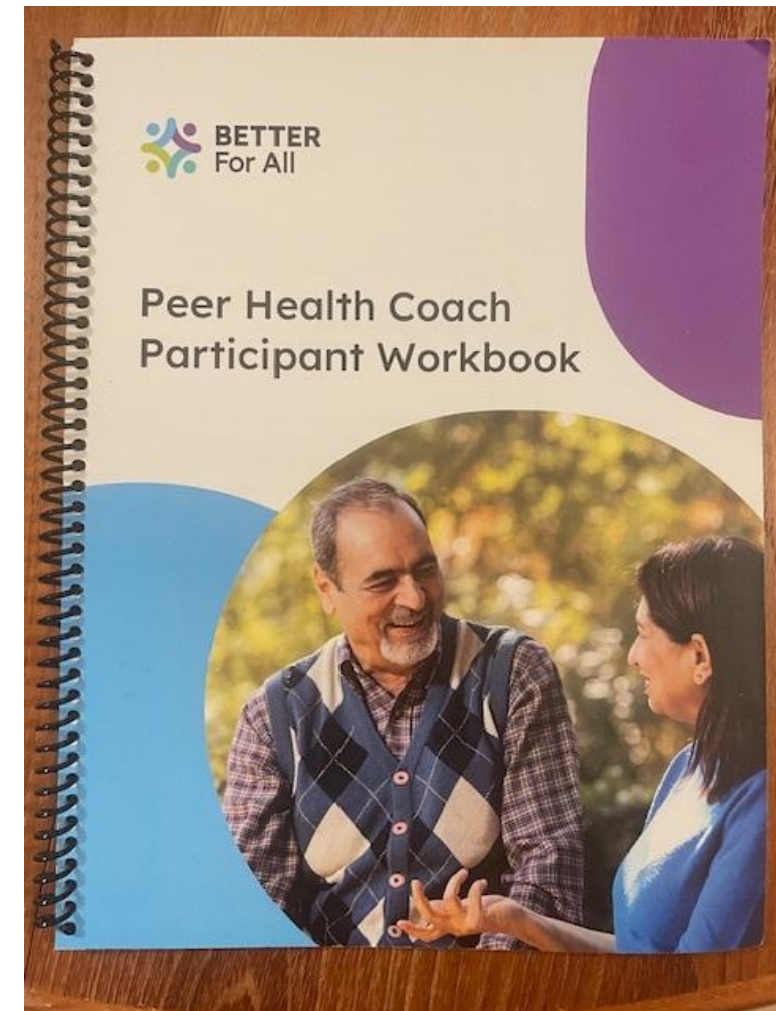


# Peer Health Coach

# Curriculum Development

Multi-disciplinary team included:

- ✓ Experts in curriculum development
- ✓ Specialist in Moodle platform design and online learning
- ✓ Researchers and academic partners
- ✓ They worked together to define Peer Health Coach competencies and training modules including **Chronic disease prevention and Motivational interviewing**



# Peer Health Coach Training program

Consisted of 9 structured units

Unit 1	Introducing the BETTER For All and Peer Health Coach Role
Unit 2	Cancer and Chronic Disease Risk Prevention
Unit 3	Health Equity
Unit 4	Fundamentals of Behaviour Change
Unit 5	Relationship Building and Boundaries
Unit 6	Goal Management
Unit 7	Finding Reliable Health Information and Community Resources
Unit 8	Using NexJ Connected Wellness
Unit 9	Training Closure



# Peer Health Coach Training Program

Online learning (on the Moodle Platform)	Virtual Learning
<ul style="list-style-type: none"><li>✓ On orientation day you will be given access to the Moodle Platform. <a href="https://betterwomen.lmshosting.ca/">https://betterwomen.lmshosting.ca/</a></li><li>✓ <b>Begin each week on the Moodle platform</b> to review the content on your own and complete forum questions and quizzes.</li><li>✓ You will be required to <b>complete 1-3 hours of online learning each week</b> for 5 weeks. These are suggested times and might take you longer.</li><li>✓ Make sure you review the material and come to the virtual sessions prepared.</li></ul>	<ul style="list-style-type: none"><li>✓ Hosted on Zoom</li><li>✓ 3 hours in length held at the end of each week</li><li>✓ Designed for continued application, discussion and practice of material learned via Moodle</li><li>✓ Facilitated by us alongside various co-facilitators, including MI expert Dr. Maya Obadia.</li></ul>



# PHC Recruitment Process

- **Screening and selection of PHCs** involved an application, two interviews, references, and criminal records check. This was supported by CCS Volunteer Experience Team
- **Comprehensive Training and Supervision** throughout the life cycle of peer health coaching including booster sessions and community of practice meetings
- **Matching Using NexJ Platform** Participants are provided with 3 top PHC matches to choose from based on gender, language, and health goals. PHCs include a short bio in their profile to help the participants decide if they are a good match
- **Role of PHCs** is to extend the care team by providing regular check-ins and support participants in achieving their health goals. Also, to help connect them to reliable health information and community resources while staying within a defined scope. (5 areas of CDPM)



# Scope of PHC Support

To support participants to make healthy lifestyle changes such as:

- ✓ **Improve diet**
- ✓ **Increase physical activity**
- ✓ **Reduce or eliminate smoking and alcohol**
- ✓ **Getting up to date on screening check-ups (mammography, HPV testing and colon screening)**



# Peer Health Coach Perspective

# Peer Health Coach: Jean Eng



## **Benefits experienced from being a Peer Health Coach:**

- Individual health accountability
- New friendships
- Knowledge gained
- Growth in skills
- Career opportunities



# Participant Feedback & Impacts

“If it weren’t for the weekly calls, I would not have met my goals, **accountability** to someone plays a huge role!”

- ✓ Didn’t feel judged
- ✓ Realistic and supportive
- ✓ Organization skills and tracking tools help tremendously (eg. Fitbit)
- ✓ Exercise has now become part of some participants’ routines;
  - Anecdotal: observed weight changes and blood pressure changes
- ✓ Consistency is key to making progress
- ✓ Learning to ask for help and being vulnerable



# **Sustainability Discovery**

# BFA Sustainability Project Objectives

To understand how the BFA program can be sustained and strengthened overtime, including:

1

Identifying the **resources, relationships, and processes** required to sustain BFA program outcomes.

2

Examining strategies to **maintain program delivery** and associated health and social benefits over time

3

Exploring approaches to **support sustained engagement** in preventive health behaviours among participants

4

Ensuring program delivery remains **equitable, contextually relevant, and accessible** to structurally marginalized populations.



# Methodology

- **Study Design:** Qualitative descriptive study
- **Sampling:** Heterogeneous purposive sampling
- **Data Collection:** Semi-structured interviews and demographic data
  - 30 participants
    - 13 Community members
    - 17 Staff members (8 PPs, 4 PHCs, 3 site administrators, 2 in dual role)
- **Data Analysis:** NVivo (Qualitative analysis) & SPSS (Descriptive statistics)

## Partner Organizations:

1. Access Alliance (College)
2. APOD
3. Village Family Health Team
4. Davenport Perth Neighbourhood CHC
5. Francophone Centre Toronto
6. Taddle Creek Family Health Team
7. Parkdale Queen West CHC



## 360° Stakeholder Input:

- BFA Program Participants
- Community Members
- Prevention Practitioners
- Peer Health Coaches
- Site Administrators
- CCS Team



# Project Timelines



# Sample Characteristics

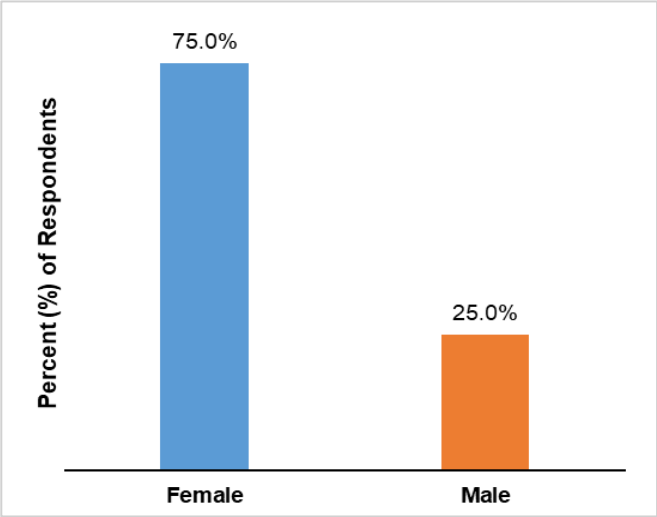


Figure 1. Percentage of respondents by gender. (N=12)

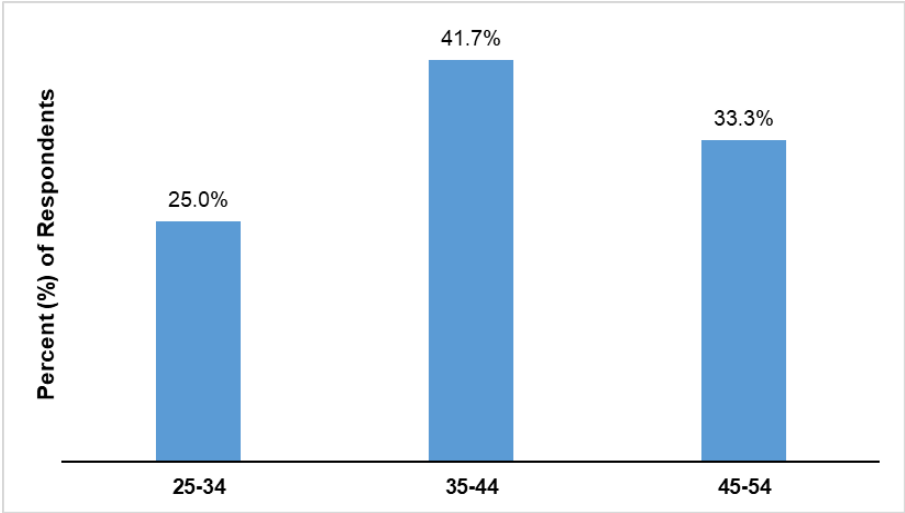


Figure 2. Percentage of respondents by age in years. (N=12)

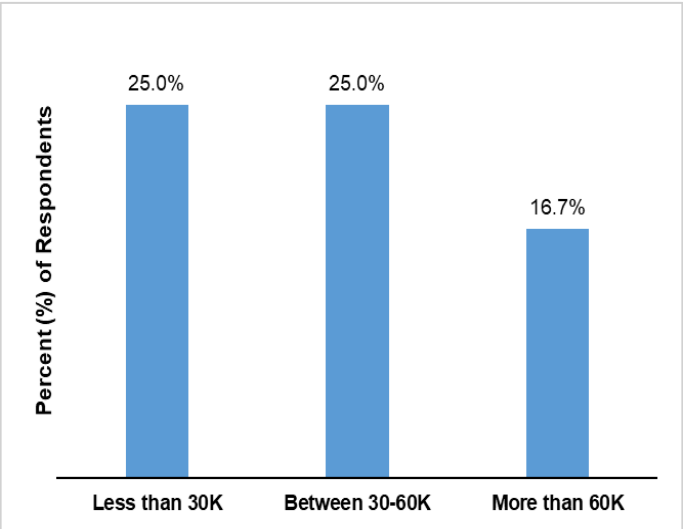


Figure 3. Percentage distribution of respondents by annual household income (N = 12).

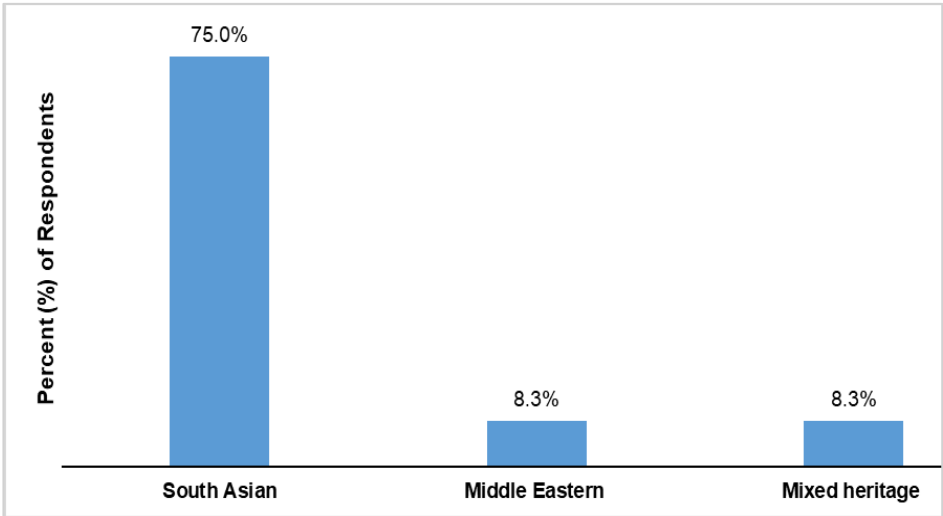


Figure 4. Percentage of respondents by ethnicity (N=12)



# Qualitative Findings

## BFA Program Participants

Themes	Key Takeaways
<b>Barriers to Participation</b>	<ul style="list-style-type: none"> <li>Socioeconomic needs, family responsibilities, transportation, language</li> </ul>
<b>Facilitators to Participation</b>	<ul style="list-style-type: none"> <li>Opportunity to share and inform the community and themselves</li> </ul>
<b>Program Experience</b>	<ul style="list-style-type: none"> <li>Respected, understood, comfortable, and easy to participate</li> </ul>
<b>Sustainability</b>	<ul style="list-style-type: none"> <li>Education of chronic disease management, socioeconomic supports</li> <li>Extension program beyond 6 months</li> </ul>

## Community Members

Themes	Key Takeaways
<b>Barriers to Participation</b>	<ul style="list-style-type: none"> <li>Competing socioeconomic priorities, transportation/weather challenges, digital barriers, cancer-related stigma</li> </ul>
<b>Current Health Needs &amp; Support</b>	<ul style="list-style-type: none"> <li>Interest in food and nutrition support</li> <li>Challenges accessing primary and specialist care</li> <li>Medication support needed</li> </ul>
<b>Facilitators to Participation</b>	<ul style="list-style-type: none"> <li>Desire to learn and contribute</li> <li>Value of PHCs</li> <li>Family history of chronic disease/cancer</li> </ul>
<b>Outreach &amp; Engagement</b>	<ul style="list-style-type: none"> <li>Flyers, community events, health ambassadors, social/religious gatherings, social media</li> </ul>
<b>Language</b>	<ul style="list-style-type: none"> <li>Accessible translations and interpreters</li> <li>Plain language preferred over medical jargon</li> </ul>

**Table 1:** Summary of key findings from BFA Program Participants (n=3).

**Table 2:** Summary of key findings from community members across seven sites participating in the BFA program (n=10).



# Qualitative Findings

## Prevention Practitioners

Themes	Key Takeaways
<b>Client Barriers</b>	<ul style="list-style-type: none"> <li>• Recognition of social determinants of health</li> <li>• Low client uptake and retention</li> </ul>
<b>Operational &amp; Administrative Barriers</b>	<ul style="list-style-type: none"> <li>• Limited session time</li> <li>• High paperwork/workload</li> <li>• Insufficient management support</li> </ul>
<b>Equity &amp; Diversity</b>	<ul style="list-style-type: none"> <li>• Culturally appropriate recommendations</li> <li>• More translated materials</li> <li>• Plain language communication</li> </ul>
<b>Program Effectiveness &amp; Value</b>	<ul style="list-style-type: none"> <li>• Value strong benefits for clients and communities</li> <li>• Motivational Interviewing valued and transferable</li> </ul>
<b>Sustainability</b>	<ul style="list-style-type: none"> <li>• Expand age eligibility and program duration</li> <li>• Integrate into Family Health Teams</li> <li>• PHC feasibility</li> <li>• Provide refresher training</li> </ul>

**Table 3:** Summary of key findings from Prevention Practitioners (n=8).

## Peer Health Coaches

Themes	Key Takeaways
<b>Implementation Barriers</b>	<ul style="list-style-type: none"> <li>• Low client uptake and retention</li> <li>• Challenges using NextJ platform</li> </ul>
<b>Training Support &amp; Motivation</b>	<ul style="list-style-type: none"> <li>• Previous family history of chronic disease/cancer</li> <li>• Connection to community</li> </ul>
<b>Program Experience</b>	<ul style="list-style-type: none"> <li>• Cultural humility and consideration</li> <li>• Address language needs</li> </ul>
<b>Sustainability</b>	<ul style="list-style-type: none"> <li>• Offer both group and one-on-one in-person sessions</li> <li>• Continue Motivational Interviewing</li> <li>• Provide refresher training</li> <li>• Maintain flexible, person-centered goals</li> <li>• Enhance support for older men with chronic disease/cancer</li> </ul>

**Table 4:** Summary of key findings from Peer Health Coaches (n=4).



# Qualitative Findings

## Site Administrators

	Themes	Key Takeaways
➔	<b>Implementation Barriers &amp; Operational Strain</b>	<ul style="list-style-type: none"><li>• High resource demands</li><li>• Administrative burden</li><li>• Low client uptake and retention</li></ul>
	<b>Equity, Inclusion &amp; Cultural Responsiveness</b>	<ul style="list-style-type: none"><li>• Need for gender-diverse training and materials, including transgender-inclusive forms</li></ul>
	<b>Program Alignment &amp; Added Value</b>	<ul style="list-style-type: none"><li>• Increased provider capacity for prevention planning</li><li>• Reduced social isolation among participant</li></ul>
➔	<b>Sustainability, Integration, &amp; System Embedding</b>	<ul style="list-style-type: none"><li>• Funding concerns</li><li>• Expand eligibility criteria and chronic disease focus</li><li>• Integrate into Family Health Teams</li><li>• Support provider referrals</li><li>• Extend program beyond 6 months</li></ul>

**Table 5:** Summary of key findings from site administrators (n=3).



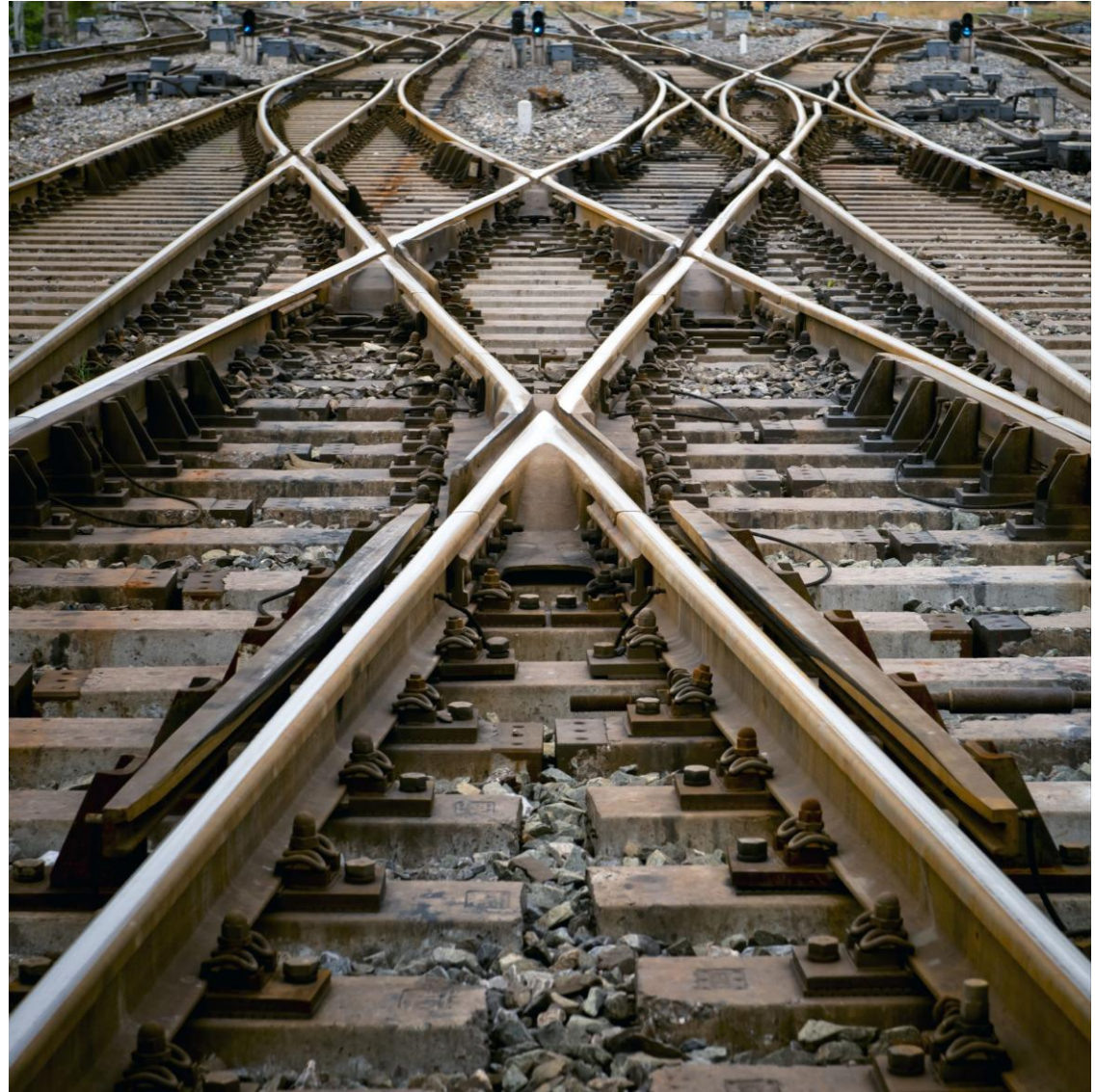
# Recommendations

- ✓ **Strengthen outreach and engagement:** Implement and sustain community health ambassador programs and expand multilingual, community-led outreach strategies.
- ✓ **Streamline operations:** Integrate BFA into primary care workflows, reduce administrative burden, and provide tiered, ongoing participant support.
- ✓ **Advance equity and inclusion:** Improve language access through multilingual, plain-language resources and revise program materials to support gender diversity and inclusive tools.
- ✓ **Support training and continuity:** Provide regular refresher training and ongoing staff development
- ✓ **Improve accessibility and delivery:** Reduce structural barriers, standardize Motivational Interviewing and offer flexible delivery formats
- ✓ **Enhance governance and evaluation:** Establish cross-site governance, standardize program evaluation, and develop long-term funding and partnership strategies



# Where do we go from here?

“Every new beginning comes from other  
beginning’s end” – Seneca the Younger



# Future Opportunities ahead?



Could **PHC curriculum** be used with other roles?

- Link Workers
- Community Health Ambassadors
- Health Coaches
- Peer navigators



Could a **Prevention Prescription** approach be used by other practitioners?



Could **Prevention visit tools** support health discussions with clients?

- Bubble Diagram
- Goal sheet
- Prevention Prescription



# Info Request Form!

[Betterforall-info@cancer.ca](mailto:Betterforall-info@cancer.ca) –BFA program email

[Arionne.Mitchell@cancer.ca](mailto:Arionne.Mitchell@cancer.ca)

[Karen.Kuzmich@cancer.ca](mailto:Karen.Kuzmich@cancer.ca)

[Ejalil@accessalliance.ca](mailto:Ejalil@accessalliance.ca) – Sustainability discovery

BETTER for All (BFA) Information  
Request from



# Spread the word

- Do you have **clients that could benefit** from a Prevention Visit and up to 6 months of Peer Health Coach support?
- Interested individuals can request to join on program webpage: <https://cancer.ca/betterforall>



[cancer.ca/betterforall](https://cancer.ca/betterforall)



# Questions or Comments ?

BETTER for All (BFA) Information  
Request from





# ACKNOWLEDGEMENTS

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## BETTER for All (BFA) Information Request from

