
PLANNING FOR INCLUSION

A Quality-Informed Outreach Tool
for Community Programs

Designed for community-based programs supporting older adults
Developed through the Senior Wellness Initiative



CHSSN

The Community Health and Social Services Network (CHSSN) was formed in 2000 to support English-speaking communities in the province of Québec in their efforts to redress health status inequalities and promote community vitality.

Through a series of projects and partnerships that link community and public partners, the CHSSN is working to strengthen networks at the local, regional and provincial level to address health determinants, influence public policy and develop services. Begun through the efforts of four founding organizations, the CHSSN now has more than 60 member organizations and is involved in over 150 projects and partnerships in the areas of primary health care, community development and population health. Their aim is to contribute to the vitality of English-speaking communities of Québec by building strategic relationships and partnerships within the health and social services system to improve access to services.

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The views expressed in this document do not necessarily reflect those of the Secrétariat aux relations avec les Québécois d'expression anglaise.

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Using this Tool in your Community Program

Supporting intentional, relational, and community-rooted engagement.

This Quality-Informed Outreach Tool supports intentional, relational approaches to engaging older adults in community programs. This tool is informed by practice within the Senior Wellness Initiative (SWI) and reflects the realities of delivering community programming across diverse settings. It helps organizations plan, reflect, and strengthen practices that build trust, reduce isolation, and foster meaningful community connection.

How to Use This Tool:

- When planning new activities or outreach approaches
- When onboarding staff or volunteers
- While developing or adapting programs
- To reflect on outreach challenges and opportunities

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Core Principles of Inclusive, Quality-Informed Outreach

Designed to support community programs in planning, delivering, and evaluating outreach

1 Relationship-Centred

- Meaningful human connection
- Consistent and reliable presence
- Trust built over time
- Responsiveness to individual needs and preferences

Quality Indicators:

- ✓ Personal phone calls or check-ins
- ✓ “What do you need?” conversations
- ✓ Warm, non-clinical communication
- ✓ Follow-up after programs or absences
- ✓ Staff are known and trusted in the community

2 Context-Responsive Outreach

Community contexts vary widely (e.g., urban, rural, remote; linguistic and cultural diversity; access to services). High-quality outreach adapts to local conditions and barriers to participation.

Quality Indicators:

- ✓ Outreach methods tailored to geography and transportation
- ✓ Multilingual/low-literacy communication
- ✓ Outreach embedded in trusted community settings (e.g., libraries, community centres, faith-based spaces, local businesses)
- ✓ Home visits where appropriate (e.g., rural or close-knit communities)
- ✓ Hybrid or virtual options where appropriate

3 Inclusion, Belonging, and Psychological Safety

Barriers to participation may include:

- fear of judgement or stigma
- social isolation or loneliness
- stigma related to seeking support
- reluctance to identify with certain labels (e.g., “senior”)
- concerns about loss of independence or autonomy

Quality Indicators:

- ✓ Language that reduces stigma (“older adults,” “community members”)
- ✓ Explicit permission to come late/leave early
- ✓ Visible welcoming gestures (greeters, ambassadors)
- ✓ Home visits offered as supportive and trust-building, not evaluative
- ✓ Activity options aligned with participants’ emotional readiness

4 Multi-Channel, Low-Barrier Communication

No single outreach method reaches everyone. Inclusive outreach uses multiple, low-barrier communication approaches.

Quality Indicators:

- ✓ Phone calls
- ✓ Printed posters in local hubs
- ✓ Community kiosks
- ✓ Monthly newsletters (digital or print)
- ✓ Direct residence partnerships
- ✓ Word-of-mouth encouragement
- ✓ Digital platforms (e.g., websites, social media) used as complementary tools

5 Partnership-Enabled Outreach

Partnerships (e.g., community organizations, cultural groups, health and social services) expand reach, strengthen trust, and improve accessibility.

Quality Indicators:

- ✓ Clear expectations with partners
- ✓ Pilots before scaling
- ✓ Mutual benefit and shared accountability
- ✓ Regular touchpoints with residence staff
- ✓ Joint programming or co-hosted events

6 Outreach as Connection and Navigation Support

For many older adults, outreach can be an entry point to information, services, and community connection.

Quality Indicators:

- ✓ Warm navigation support
- ✓ Support for trial classes
- ✓ Instructor heads-up for newcomers
- ✓ Aligning programs with participants' interests, needs, and abilities
- ✓ Respectful conversations about safety, preferences, and participation

7 Co-Design and Responsiveness

High-quality outreach involves listening deeply and adapting programming based on participants' expressed needs, interests, and readiness.

Quality Indicators:

- ✓ Annual planning meetings or listening groups
- ✓ Continuous feedback loops
- ✓ Programming shifts based on annual listening sessions (e.g., "lighter topics" or "more creative activities").
- ✓ Participants have meaningful opportunities to shape and influence programs

Supporting Participation and Shared Engagement in Community Programs

(adapted from Kwong Kam, 2023)

Participation is a foundation of inclusive, high-quality community programming. It supports older adults in shaping activities, contributing their knowledge and experience, and engaging in ways that reflect their interests and preferences. Engagement is not fixed. It can evolve over time and may look different for each person, depending on context, capacity, and choice.

The Engagement Ladder

The Engagement Ladder describes different ways people may participate in programs and community life. Participation can shift over time, and all forms of engagement are valid.

Level 7	Shared decision-making and influence over programs and services
Level 6	Working in partnership and sharing responsibility
Level 5	Taking active roles in groups and projects
Level 4	Supporting program activities
Level 3	Contributing to program implementation
Level 2	Opportunities for choice and input
Level 1	Being consulted and sharing feedback

Using the Engagement Ladder in Practice:

- Recognize and value all forms of participation, including early or low-barrier engagement.
- Notice when participants express interest in deeper involvement and create opportunities where appropriate.
- Support participation in ways that align with individual preferences and readiness.
- Use the ladder as a reflective tool to inform outreach approaches, co-design processes and program planning.

Quality Standards Indicators

Use these indicators to reflect on outreach practices and identify opportunities to strengthen connection, accessibility, safety, and belonging.

These indicators are intended as a reflective tool rather than a checklist. Not all indicators will apply in every context.

1. Relational Indicators

Participants feel recognized and welcomed

Staff understand participants' health, communication, and accessibility needs

Outreach is personalized and responsive

Food or refreshments are offered where appropriate to support comfort, connection, and cultural inclusion

Staff understand how participants travel to and from programs

2. Accessibility Indicators

Programs are low-cost or free

Participation is flexible and low-pressure

Hybrid or virtual options are available where appropriate

Materials are delivered or accessible when needed

Translation or plain-language supports are available

3. Cultural & Identity Indicators

Avoid unnecessary or stigmatizing labels (e.g., "frail")

Engagement approaches are tailored to reach underrepresented groups (e.g., men, cultural diverse communities)

Practices respect and affirm diverse identities, including cultural, linguistic, newcomer, 2SLGBTQQIA+, and racialized communities

4. Safety & Readiness Indicators

Regular check-ins support awareness of cognitive or functional changes

Transportation needs and safety are considered and supported (e.g., walking groups, transit support)

Staff trained to recognize and respond to emerging concerns

Clear pathways exist for referrals or additional support, where appropriate

Trial or introductory sessions are available before full participation

5. Partnership Indicators

Partnerships with community organizations or service providers

Collaborative or co-hosted activities

Shared resources (e.g., space, volunteers, outreach channels)

Mutual expectations are clearly defined

Regular communication and coordination with partners



Strengthening Inclusive Outreach and Access

(Adapted from the National Council on Aging)

Some older adults may not participate in community programs and are often described as “hard to reach.” It is important to identify where existing outreach approaches do not align with older adults’ needs, preferences or circumstances. The strategies below focus on strengthening outreach approaches to reduce barriers, build trust, and expand access to community programs.

Expanding Reach through Community Connections

- Partner with local services and organizations (e.g., health, social services, emergency services).
- Connect through trusted community spaces (e.g., faith-based groups, cultural organizations, libraries)
- Use local media and informal communication channels (e.g., community newspapers, bulletin boards)
- Engage housing providers and community living environments
- Leverage informal networks (e.g., peers, neighbours, family members)

Maintaining Connection with People Not Currently Participating

- Offer check-ins (e.g., phone, informal outreach) to maintain connection
- Support intergenerational or peer-based connections where appropriate
- Adapt activities to accommodate different abilities and preferences
- Provide low-barrier opportunities for social connection (e.g., meal or companionship programs)
- Address practical barriers such as transportation and accessibility
- Offer programs at varied times (including evenings and weekends), recognizing that many older adults have work, caregiving, or other commitments

Reflecting on Reach and Engagement

Monitor participation patterns following outreach efforts and gather feedback to understand what supports comfort, accessibility, and meaningful engagement. Inclusive outreach is an ongoing process of learning, adapting, and building trust over time.

SMART Outreach Planning Tool

A structured tool to support intentional, inclusive outreach planning.

Your Reflections & Insights

Reflect on your outreach from the previous season and gather input from team members about what supported engagement and where barriers may have existed. Consider who is currently not participating and how your outreach could better support access and inclusion.

Use these insights to shape outreach goals that are specific, measurable, achievable, relevant, and time-bound, while remaining responsive to your community context.

Use the table below to map out your goals and track progress over time.

Goal (Specific)	How Success is Measured	Steps to Achieve	Why it Matters (Relevant)	Timeline (Time-bound)

SMART Outreach Examples

Sample SMART Outreach Goals (Adaptable to Your Community Context)

Goal (Specific)	How Success is Measured	Steps to Achieve	Why it Matters (Relevant)	Timeline (Time-bound)
1. Make personalized, relationship-centred outreach calls to older adults in the community.	20 calls per month, across diverse areas of the catchment.	Calls can be made by staff or trained volunteers.	Supports connection, reduces isolation, increases program uptake.	Review progress quarterly.
Goal 1 Summary: By March 31, our team will complete 60 personalized outreach calls (20/month) to older adults, focusing on relationship-building and identifying individual needs.				
2. Strengthen first-time participant retention through reminder calls, buddy systems, and instructor briefings.	20% increase in first-time participants who return for a second session.	Uses existing staff practices (e.g., follow-ups).	Reduces drop-off, builds continuity.	Over the next 4 months.
Goal 2 Summary: From January to April, we will increase first-time participant return rates by 20% by providing reminder calls, a warm welcome, and follow-up check-ins.				
3. Build connections with one underrepresented group (e.g., men, rural older adults, low-income older adults) and co-develop a tailored outreach approach	1 outreach activity; at least 6 new connections established.	Uses small pilot.	Supports equity and access.	Within 12 weeks.
Goal 3 Summary: By March 15, we will launch one outreach activity co-developed with an underrepresented group and establish at least 6 new connections.				

Goal (Specific)	How Success is Measured	Steps to Achieve	Why it Matters (Relevant)	Timeline (Time-bound)
4. Strengthen follow-up practices to supporting ongoing connection and participation.	Follow-up completed for 90% of absences.	Short calls or texts; volunteers can help.	Supports safety, belonging, and early detection of risk.	Implement within 2 months.
Goal 4 Summary: By February 28, we will implement follow-up practices to ensure 90% of missed sessions receive a check-in within 48 hours.				
5. Support participants to increase their level of engagement (e.g., from sharing feedback to helping shape activities or take on small roles).	At least 5 participants demonstrate increased engagement (e.g., contributing ideas, taking on small roles, or participating more actively)	Invite participants to choose between activity options; Offer small, low-pressure volunteer roles (greeting, setting up materials); Hold informal check-ins to ask about interests and comfort levels.	Strengthens empowerment, belonging, and participant ownership of programming.	Within 3 months.
Goal 5 Summary: By April 30, we will support at least five participants to increase their level of engagement through small roles, shared decision-making, and ongoing check-ins.				
6. Build connections with older adults who are not currently participating by adapting outreach approaches through trusted community partners	Make 6 new connections and complete at least 3 follow-up conversations.	Partner with a local connector (e.g., social services, housing complex, faith community); Offer low-barrier outreach (e.g., phone check-ins, informal visits, presence in community spaces).	Reduces isolation, increases equity of access, and strengthens community presence.	Within 10–12 weeks.
Goal 6 Summary: By March 15, we will build connections with at least six older adults not currently participating in our community programs by working with trusted community partners and using low-barrier outreach approaches.				

Supportive Conversation Examples

These examples illustrate conversational approaches that support autonomy, build trust, and reduce barriers to participation. They are intended as flexible prompts to support respectful, person-centred conversations.

A. Opening the Conversation and Building Trust

Goal: Create a welcoming, low-pressure starting point where people feel seen, heard, and comfortable sharing.

Example Lines:

- “What’s been taking up your time or energy lately?”
- “What kinds of things have you been enjoying these days?”
- “It sounds like you’ve had a lot going on. How have you been managing?”
- “Is there anything you’ve been wanting to try, but haven’t had a chance yet?”
- “If you’re open to it, I can check in after the first session to see how it felt.”

B. Understanding Context and Reducing Barriers

Goal: Explore practical, emotional, and contextual factors that shape participation, without making assumptions.

Example Lines:

- “What does getting out to something like this usually look like for you?”
- “What tends to make it easier, or harder, to take part in things?”
- “Would it help to look at options that are closer to home, or easier to get to?”
- “Some people prefer smaller groups or quieter spaces. What feels most comfortable to you?”
- “Are there places or activities in the community where you already feel at ease?”



C. Supporting Choice and Low-Pressure Participation

Goal: Reduce pressure, normalize different levels of participation, and support people to engage in ways that feel right for them.

Example Lines:

- “You’re welcome to come late, leave early, or just observe, whatever works.”
- “You don’t have to commit, think of it as a ‘try it and see’ opportunity.”
- “If it’s helpful, you can bring a friend or family member.”

D. Supporting Safety, Comfort, and Readiness

Goal: Ensure that the program or activity aligns with the person’s comfort, abilities, and sense of safety: physically, cognitively, and emotionally.

Example Lines:

- “How does this space feel for you in terms of getting around or settling in?”
- “If anything ever feels off or overwhelming, we can adjust. Just let us know.”
- “Some programs might feel more comfortable than others, what kind of pace feels right for you?”
- “It sounds like you’ve noticed some changes lately. Would it be okay if we explored supports together?”

E. Inviting Input, Ownership, and Co-Designness

Goal: Create opportunities for people to shape programs, express preferences, and take on meaningful roles over time.

Example Lines:

- “What kinds of activities feel most meaningful or enjoyable to you?”
- “Is there anything you wish existed here that we haven’t tried yet?”
- “What would make this feel more welcoming or useful for you?”
- “Would you be interested in helping shape or suggest ideas for future activities?”
- “If you were designing an event for others, what would you include?”

