



Advant**Age**
Ontario

Advancing Senior Care

Feedback on Ontario's Proposed Dementia Care Framework

September 1, 2026

Summary of Recommendations

Following is a summary of our recommendations set out in this submission, which are grouped under four priorities:

1. Dementia Care and Support Continuum:
 - i. Make prevention, risk reduction, early detection, and early intervention core elements of the dementia framework.
 - ii. Recognize community dementia programs and adult day services as key supports for aging in place.
 - iii. Recognize and address dementia care options between home and long-term care.
 - iv. Reflect relationship- and person-centred dementia care through specialized supports, design, and transitions.
 - v. Incorporate palliative approaches into dementia care planning.
2. Public Awareness, Education and Stigma Reduction:
 - i. Recognize dementia awareness, stigma reduction, and education as foundational elements across the dementia care continuum.
 - ii. Recognize caregivers as essential partners in dementia care and incorporate caregiver supports.
3. Equity, Inclusion and Underserved Populations:
 - i. Recognize culturally safe, inclusive, and population-specific approaches.
4. Implementation, Accountability and Sustainability:
 - i. Recognize system navigation, care coordination, and integrated information across sectors.
 - ii. Embed workforce planning, dementia expertise, and system capacity.
 - iii. Recognize accountability, continuous evaluation, and sustainable investments.

Introduction

AdvantAge Ontario appreciates the opportunity to provide feedback on the province's proposed Dementia Care Framework. We are broadly supportive of the framework's focus on person-centred dementia care, equitable access, navigation and care transitions, workforce capability, and culturally safe care. We also support the province's objective of improving coordination across health care, long-term care, retirement homes, and community-based services.

Dementia encompasses a range of conditions with different symptoms, progression patterns, and impacts on daily functioning. As such, individuals living with dementia will have varying care needs, and it is important that this framework recognizes and supports those needs. Many people living with dementia can continue to age at home with the right support in place, while others may be required to move to other care settings. A flexible, person-centred approach that considers all aspects of the seniors' care continuum is therefore critical to meeting the diverse needs of Ontarians living with dementia.

The proposed framework appropriately identifies many of the challenges currently experienced by people living with dementia and their care partners, including fragmented care pathways, difficulties navigating the system, inconsistent access to services, workforce challenges, and disparities across regions and populations. Many of the challenges identified are aligned with other existing work in this area, including the Canadian federal government's dementia strategy¹, the World Health Organization's (WHO) Global action plan on the public health response to dementia², and the Alzheimer's Society Local Dementia Strategy Toolkit³.

AdvantAge Ontario consulted several of our members from across the seniors' care continuum, including long-term care homes, seniors' housing providers, community support service organizations, municipal providers, retirement homes, and not-for-profit health and social service organizations. Members welcomed the opportunity to provide feedback and strongly supported the development of a provincial dementia care framework.

Several consistent themes emerged through the consultation. Members emphasized that the framework should not only address current gaps in dementia care but should also provide a clear vision for how Ontario will meet the major growth in demand for dementia care anticipated over the next decade. It should also include a roadmap for implementation, improve coordination across sectors, support aging in place, strengthen community-based care, address future capacity needs, and enable people living with dementia and their care partners to access the right support at the right time regardless of where they live.

Commentary

A Dementia Care and Support Continuum

Dementia is one of the fastest-growing health and seniors' care challenges facing Ontario. More than 334,500 Ontarians currently live with dementia⁴, representing approximately 43% of all Canadians living with the condition⁵. The number of people living with dementia in Canada is projected to increase from approximately 772,000 today to nearly one million by 2030⁶, while the number of Ontarians living with dementia is expected to triple by 2050¹. These projections underscore the urgency of building a dementia care system that is prepared not only for today's needs, but also for the significant increase in demand expected in the decades ahead.

In order to meet this challenge, we need the dementia framework to be transformative and rooted in a vision for the future of dementia care rather than the limitations of the current system. It should identify the capacity, workforce, housing, community supports, and care models that Ontario will require over the next decade. The framework should include a clear roadmap of services, supports, and care models needed throughout the dementia care journey, from prevention and diagnosis through end of life. The following sections of the submission highlight key areas where the framework could more clearly articulate this future vision and identify the system's capacity, supports, and care models required to achieve it.

Prevention, Risk Reduction and Early Identification

Our members emphasized that the current system often responds only once individuals or caregivers reach a crisis. They recommended that prevention, risk reduction, and early intervention become more explicit pillars of the framework. There is growing evidence around modifiable risk factors for dementia⁷ that can prevent and/or slow down the disease. The social and built environments that individuals live in can also contribute to their overall health and wellbeing. There is an important opportunity for the provincial dementia care framework to promote healthy aging and protective factors to reduce the risk of developing dementia in the first place. The framework should also include public awareness initiatives on risk factors and potential interventions. A robust framework can help by delaying the onset or progression of dementia and improving the quality of life and health outcomes for older adults, while reducing future demand on health, community, and long-term care services and support the sustainability of the healthcare workforce and broader seniors' care system.

Additionally, while new disease-modifying medications for dementia are now available, their effectiveness depends on individuals receiving a diagnosis of dementia early in the course of the disease. Currently, however, it can take up to two years for a person to receive a dementia diagnosis. Without timely access to assessment and diagnosis, many individuals may miss the opportunity to benefit from these emerging treatments. Early detection and timely diagnosis

also create opportunities for advance care planning, informed decision-making, and the integration of palliative approaches throughout the dementia journey, rather than only at the end of life. Early and timely diagnosis of dementia must therefore be recognized as a key element of the framework.

Recommendations:

- Include dementia prevention, brain health promotion, and risk reduction as core elements of the framework.
- Recognize early identification, assessment, diagnosis, intervention, and post-diagnostic support as essential components of the dementia care continuum, supported by timely access to assessment and diagnosis and clear pathways to treatment, information, community services, and caregiver supports.

Community Supports for People Living with Dementia and their Care Partners

One of the strongest themes emerging from the consultation was the need to ensure that the framework is not mostly focused on long-term care but also includes a strong focus on community-based support. In fact, around 1 in 10 of newly admitted residents in long-term care homes could have been cared for at home with the right supports in place⁸. Given that 81% of older Canadians want to age in their home⁹, investments in home and community care, navigation supports, and age-friendly communities will be essential to helping those living with dementia remain independent for as long as possible.

Members identified several areas within the community where the framework should prioritize investments to improve access to quality primary care and memory clinics to allow for earlier diagnosis and intervention as a proactive approach, rather than intervening only after individuals have reached crisis. Part of these investments should include education, resources, and support for primary care providers to ensure they are adequately equipped to help individuals and families navigate the dementia care system. An increase in adult day programs and community-based dementia programs, along with broader eligibility criteria to improve access to these services, and promoting greater awareness of available community services, is also important, given that these supports often serve as critical connectors across the continuum of care and enable those with dementia to live at home longer. These programs also provide essential respite for care partners.

In addition, members highlighted the need for greater recognition of rehabilitation and restorative care options for people living with dementia. There is a major gap in specialized rehabilitation services and appropriate transitional care pathways within hospitals and in the community, which often results in individuals being directed toward long-term care prematurely. Ensuring that any framework includes strengthening these services would help ensure that people living with dementia receive care in the most appropriate setting and avoid unnecessary placement in long-term care and/or hospital settings.

Recommendations:

- Reflect the role of innovative aging-in-place initiatives and community-based dementia programs in supporting people living with dementia and their care partners in the community.
- Recognize adult day programs, rehabilitation, and restorative care options as an important component of community-based dementia care.

Housing and Congregate Care

Members consistently highlighted a significant gap in the continuum of care between traditional home care and long-term care. Bridging this gap should be a critical piece of the province's framework to ensure those living with dementia receive care in the right place at the right time.

One example of how gaps within the current system can leave people without appropriate access to the level of care they need at the right time is those living with moderate dementia, which accounts for approximately 30% of people with Alzheimer's dementia¹⁰. These individuals may be best supported through supportive housing or assisted living options, as they often require more support than can realistically and safely be provided at home. Many cannot afford retirement home accommodations and related additional care costs, and those with moderate dementia are lower on the long-term care priority waitlist, leaving them without an appropriate care option.

This challenge highlights a broader gap in Ontario's continuum of seniors' care. Members noted that the framework should more clearly articulate the important role of supportive housing, assisted living, and other congregate care models within the continuum of care. Establishing clear and consistent definitions, eligibility criteria, and expectations for service delivery within the framework would improve care planning and system navigation, while helping people living with dementia gain access to the right supports in the right setting at the right time. A stronger foundation for these models is also needed to support future growth in capacity. Ontario continues to lack sufficient housing options and supply for individuals whose needs exceed what can be safely provided through traditional home care, but who do not yet require long-term care. Expanding supportive housing and assisted living capacity would improve the quality of life for people living with dementia and help them remain in the community longer. It would also reduce pressure on hospital and long-term care homes by providing a more cost-effective alternative to higher-intensity, higher cost care settings.

Dementia-Friendly Communities and Environments

While expanding supportive housing and assisted living capacity is a critical part of strengthening Ontario's dementia care system, the physical environment in which care is delivered is also important. Members stressed the need for more dementia-friendly care

environments that support safety, independence, well-being, and quality of life for people living with dementia. Some examples of dementia-friendly care environments include small-home models, such as in the County of Lambton's dementia-friendly long-term care setting, household-style models, custom building design, specialized dementia care environments, and flexible congregate living arrangements. These approaches can help create more familiar, person-centred settings that better meet the needs of people living with dementia. However, current funding mechanisms and design requirements can create barriers to implementing and expanding these models, limiting their availability despite growing demand.

Members also noted that the framework should recognize the role that the built and community environment plays in supporting people living with dementia. Dementia-friendly and age-friendly approaches to housing, public spaces, transportation, and community facilities can promote independence, inclusion, safety, and well-being while helping people remain active and engaged in their communities. Recognizing the importance of supportive community environments would reinforce a whole-of-society approach to dementia care that extends beyond formal care settings.

Members also highlighted the importance of ensuring sufficient access to specialized dementia care and behavioural supports across the continuum of care, such as through Behavioural Supports Ontario (BSO), Behavioural Support Units (BSU), and other specialized dementia care services. Within long-term care specifically, specialized dementia care models and BSUs remain a valuable resource for supporting residents with dementia who have complex behaviours. However, the specialized units remain limited and are increasingly serving residents with a broader range of complex behavioural needs beyond dementia. As a result, their ability to function as dedicated dementia-focused resources can be diminished. Expanding access to specialized dementia care units and dementia-focused expertise will be critical to meeting future demand and maintaining system capacity as the prevalence of dementia continues to grow.

Transitions, Campus of Care and Spousal Reunification

Members also identified challenges related to transitions between care settings, particularly for people living with dementia who rely on established caregivers, support networks, and familiar environments. Transitions between retirement homes, supportive housing, hospitals, specialized dementia units, and long-term care homes can be disruptive and distressing. Members highlighted circumstances where spouses living together in retirement homes, supportive housing, or campuses of care are separated when one partner requires a different level of care. Existing placement and prioritization processes often emphasize bed availability and urgency of need rather than continuity of relationships and support networks. The framework should recognize the importance of relationship- and person-centred transitions that seek to maintain caregiver relationships, preserve established supports, avoid unnecessary disruption wherever possible, and prioritize keeping spouses together.

Recommendations:

- Recognize and address gaps in the “missing middle” between community living and long-term care, including the role of community-based housing and care options that support aging in place.
- Clearly articulate the role of supportive housing, assisted living, and congregate care models within the dementia care continuum.
- Incorporate dementia-friendly design principles across housing and congregate care settings.
- Recognize diverse models of dementia care, including small-home and household-based approaches.
- Reflect the need for specialized behavioural and dementia supports across the continuum of care.
- Recognize the importance of campus-of-care transitions and spousal reunification within the framework’s approach to relationship- and person-centred care and transitions.

Palliative Care and Advanced Dementia

Members noted that palliative care was largely absent from the framework despite dementia being a progressive, life-limiting condition. People living with dementia have more difficulty accessing end-of-life care than those diagnosed with other life-limiting illnesses. A lack of a palliative approach can lead to poor management of symptoms and an overall reduced quality of life^{7,11}. A palliative approach should be integrated throughout the dementia journey, beginning at diagnosis and continuing alongside treatment and supportive care.

Recommendations:

- Incorporate palliative approaches into dementia care planning throughout the dementia care continuum.
- Recognize advance care planning earlier in the dementia journey.
- Reflect the importance of equitable access to dementia-informed palliative care services and culturally appropriate end-of-life support.

Caregivers

Including care partners is a critical but underdeveloped component of the framework. Members noted that caregivers are often the first to recognize changes in cognition, behaviour, and functioning, yet many lack the information and support needed to identify early warning signs and access appropriate services. Individuals often enter the formal care system only once caregiver burnout has reached a crisis point, underscoring the importance of supporting care partners earlier in the dementia journey. Improving caregiver education and awareness could support earlier intervention, improve care planning, facilitate timely referrals, and help reduce

caregiver stress and burnout. Increased access to overnight respite programs and other caregiver supports would also help reduce caregiver burnout.

Caregivers are also often responsible for significant out-of-pocket costs to support the person living with dementia. On average, a caregiver spends \$4,600 annually for each person they care for with dementia¹². These costs do not consider the effects caregiving has on caregivers who are employed and must reduce their hours of work to care for their loved one with dementia. While there are federal and Ontario tax measures in place that recognize the financial impact of caregiving, these incentives are limited and may lack public awareness of their availability.

Recommendations:

- Recognize caregivers as essential partners in dementia care.
- Recognize respite services as critical support for caregivers.
- Reflect the importance of caregiver education, navigation, and support throughout the dementia journey.

Public Awareness, Education and Stigma Reduction

Stigma remains a significant barrier and can contribute to delays in early diagnosis, help-seeking, care planning, and community engagement. Members noted that people often delay seeking support because of misconceptions about dementia, fear of diagnosis, or concern about losing independence. Addressing stigma and understanding of dementia through public education and awareness is foundational to improving dementia care outcomes and maximizing quality of life. This should include promoting relationship- and person-centred approaches and language that recognize the individuality, strengths, preferences, and rights of people living with dementia, rather than defining them solely by their diagnosis. There are also opportunities to improve dementia education for the public, primary care providers, community organizations, emergency response personnel, and other service providers not traditionally considered part of the dementia care system but that could be targeted to increase age-friendliness and dementia-inclusive environments and quality of care.

Recommendations:

- Include public awareness and stigma reduction as core elements within the framework, including the promotion of person-centred language and approaches that uphold the dignity, autonomy, and inclusion of people living with dementia
- Recognize the importance of dementia education for community-based service providers, first responders, and other sectors interacting with people living with dementia.

Equity, Inclusion and Underserved Populations

We support the framework's emphasis on equity but members identified several populations that would benefit from more explicit consideration, including northern and rural populations, individuals with young-onset dementia and dual-diagnoses, people with intellectual and developmental disabilities, diverse cultural communities, and those with limited access to culturally and linguistically appropriate services. Access to culturally appropriate care and services is particularly important for people living with dementia, as familiar foods, customs, and faith practices can evoke meaningful memories and provide a sense of comfort and security. These connections can improve quality of life and support relationship- and person-centred dementia care.

Language considerations, including for Francophone populations, appear to be lacking in the proposed framework. Language is an important equity consideration and becomes increasingly important as dementia progresses, as those living with dementia often revert to their mother tongue. Access to services in a person's preferred language was viewed as a key component of quality care and should be more explicitly reflected within the provincial framework's equity and cultural safety principles.

Indigenous peoples and communities should also be considered, as the population living with dementia is increasing more rapidly in First Nations populations compared with the general population¹³. The proposed key performance indicator (KPI) equity lens should recognize Indigenous health and wellbeing considerations as well as the impact of institutionalization on these individuals who are often survivors of residential schools. While cultural appropriateness is referenced broadly, members emphasized the need for specific measures, indicators, and strategies that reflect the unique experiences, needs, and priorities of Indigenous peoples. Working with Indigenous-led organizations, researchers, and community partners that are already advancing culturally appropriate approaches to dementia, aging, palliative care, and caregiver support are also important. Implementation should be informed by these Indigenous communities and organizations with expertise in Indigenous health, aging, and dementia care. The framework presents an opportunity to build on existing Indigenous knowledge, resources, and leading practices rather than creating parallel approaches.

Several members also highlighted service-access challenges faced by individuals with young-onset dementia (i.e., dementia diagnosed before the age of 65) and those living with a dual diagnosis, as both are among the most underserved populations within the current system. A lack of awareness of young-onset dementia can lead to delays in diagnosis and therefore access to age-appropriate services, support, and treatments. Similarly, individuals living with a dual diagnosis may face barriers to accessing services because they do not clearly meet existing eligibility criteria for either diagnosis, resulting in unmet care needs.

Members living in northern and rural communities continue to face unique and persistent barriers to accessing dementia care and support services. These regions are disproportionately

affected by health human resource shortages, limited access to specialists and diagnostic services, fewer community-based supports, and significant travel distances between communities. As a result, individuals living with dementia and their caregivers often experience delays in diagnosis, treatment, and ongoing care. The framework should explicitly recognize the distinct realities of northern and rural communities and include dedicated, sustainable, and culturally appropriate solutions to ensure equitable access to care.

Recommendations:

- Embed culturally safe and language-accessible dementia approaches throughout the framework while ensuring the diverse needs, experiences, and barriers faced by underserved and historically marginalized populations are reflected throughout.
- Recognize the importance of Indigenous-led dementia care approaches and meaningful partnerships with Indigenous-led organizations and communities.
- Reflect the unique needs of rural and northern communities within the framework (e.g., dedicated funding and virtual care supports).
- Recognize people living with young-onset dementia and a dual diagnosis as requiring distinct care pathways and supports.

Implementation, Accountability and Sustainability

The successful implementation of this framework depends on a nimble, responsive, integrated, and easy to navigate healthcare and social services system. Dementia care currently spans multiple ministries, Ontario Health, Ontario Health Teams, Ontario Health atHome, hospitals, long-term care homes, retirement homes, housing providers, community support services, municipalities, and primary care providers. Without clear governance and accountability mechanisms, there is a risk that existing fragmentation will persist.

A more explicit articulation of the dementia care continuum as outlined earlier in this paper, clarity of the complementary roles of each sector along that continuum, established practical mechanisms for coordination across the system to link people to proper expertise and care throughout their dementia journey, and an understanding of who will act if gaps in the system remain should form the foundation of the framework. Establishing this shared vision will help guide implementation and ensure a coordinated and integrated approach to dementia care.

The following sections outline key considerations in each of these areas and their importance to the successful implementation of the framework.

System Integration and Navigation

We welcome the proposed framework's recognition of system navigation as a key priority, as navigation was identified by our membership as one of the most significant challenges facing

people living with dementia and their care partners. Members described fragmented referral pathways, inconsistent awareness of available services, weak connections between primary care and community services, and challenges navigating supports across sectors and regions.

Members emphasized that navigation must be embedded within existing structures, including Ontario Health Teams, Ontario Health atHome, municipalities, primary care providers, and community support services, rather than creating parallel systems.

Several municipalities across Ontario have successfully advanced integrated approaches to care coordination through age-friendly community initiatives and dementia-inclusive planning (e.g., the cities of Toronto and Hamilton). These efforts have helped strengthen connections between health, social, housing, transportation, and community support services, improving navigation and access to care. There is an opportunity to enhance communication and knowledge sharing between municipalities to promote leading practices. Leveraging successful community models can help improve transitions and create a more seamless and supportive experience for individuals and their families.

Digital health and information sharing were also raised as important considerations for system integration and navigation. Members recommended aligning dementia care planning with broader provincial digital health initiatives to support shared care plans, coordinated records, and smoother transitions between care settings.

Recommendations:

- Establish clear system navigation, coordinated care planning, and integrated care pathways across sectors (i.e., health, social services, community programs, housing, and long-term care) as foundational elements of the framework and essential to integrated dementia care.
- Promote information sharing and alignment with provincial digital health initiatives.

Workforce Capacity, Education and Training

Members welcomed the framework's focus on workforce capability but felt that the discussion was largely framed around training rather than broader system capacity. A healthcare and social services workforce that is properly trained and available in the right numbers is a critical element to making the implementation of this framework successful.

Ontario's dementia care system must prepare not only for current needs but also for future demand. The framework should consider what dementia care will require over the next 10 to 15 years and model how Ontario will recruit, educate, train, and place staff along the continuum of dementia care. This is critical to being able to care for Ontario's aging population. Dementia education should be integrated into the core curriculum of health professional and care provider training programs in educational institutions, rather than being delivered primarily through

workplace-based education. Embedding dementia competencies early in training would help ensure a more consistent foundation of knowledge and a shared approach to dementia care across the seniors' care continuum. It would also reduce the financial and operational burden on care settings, which often incur significant costs related to staff training, including back-fill coverage and other workforce pressures.

Many members described significant existing workforce pressures across long-term care, supportive housing, retirement homes, community support services, and home and community care. These challenges include staff recruitment difficulties and retention challenges, limited access to specialized dementia expertise, rural and northern workforce shortages, growing care complexity, and insufficient interdisciplinary supports. Addressing these current workforce pressures is essential to ensure the system has the capacity needed to meet the growing demand for dementia care across the seniors' care continuum.

Recommendations:

- Recognize long-term dementia workforce and capacity planning as critical enablers of successful dementia care.
- Incorporate future dementia prevalence and demand projections within long-term workforce planning.
- Reflect the need for access to specialized dementia expertise across the continuum of care.
- Recognize workforce challenges in rural, northern, and underserved communities within the framework.
- Promote dementia education and competencies within health professional training programs as foundational workforce expectations.

Measurement and Funding

Members emphasized the importance of developing meaningful and consistent KPIs to measure progress across the dementia-care continuum. Concepts such as person-centred care, quality care planning, and relational and cultural experiences, while important to understand, can be difficult to define and measure consistently, and caution should remain when relying on subjective indicators alone. Several members highlighted that considerable work has already been undertaken by organizations and sector partners to develop indicators and best practices related to person-centred dementia care. Existing provincial and national dementia quality frameworks, including Ontario's Dementia Quality Standard^{14,15} and related quality measurement initiatives^{16,17,18,19,20} should be leveraged, where possible. Members further stressed that KPIs should take a system-wide approach and not be limited to non-acute settings. Performance measurement should capture experiences and outcomes across the full continuum of care, including primary care, hospitals, community services, retirement homes, and long-term care, to avoid reinforcing silos and to better reflect the interconnected nature of dementia care.

delivery. Robust, cross-sector performance measurement is important for the sustainability of the framework, as it creates accountability, enables continuous quality improvement, and provides the evidence needed to assess outcomes, allocate resources effectively, and adapt the strategy in response to emerging needs and priorities.

Successful implementation will also require sustainable and predictable funding. Many organizations described challenges associated with short-term or pilot-based funding approaches that make long-term planning difficult.

Members also emphasized the importance of evaluating existing dementia-related programs and investments as part of implementation planning. While Ontario has invested in initiatives such as BSO, adult day programs, Community Aging in Place Supportive Living (CAPSL), and other community-based services, members questioned whether sufficient evaluation mechanisms are in place to determine whether these programs are achieving intended outcomes, meeting local needs, and providing value for investment. Ongoing evaluation and continuous improvement should be built into the framework to ensure existing and future investments are directed toward services that demonstrably improve outcomes for people living with dementia and their care partners.

Recommendations:

- Develop a formal implementation plan accompanying the framework.
- Establish clear accountability, governance, and reporting structures with defined roles, responsibilities, and performance measures. Some performance measures may include the following:
 - time to diagnosis
 - caregiver burden scores
 - memory clinic wait-times
 - avoidable emergency department visits
 - alternate level of care (ALC) days attributable to dementia
 - long-term care waitlist times
 - access to respite
 - hospital readmissions
- Establish evaluation and continuous quality improvement processes to assess the impact, outcomes, and effectiveness of existing and future dementia-related programs and investments.
- Align implementation with sustainable, multi-year funding commitments.

Conclusion

AdvantAge Ontario members strongly support the province's efforts to develop a dementia care framework and welcome the opportunity to contribute to this important work. The framework presents a significant opportunity to strengthen dementia care across Ontario; however, success will depend on ensuring the entire dementia care continuum is reflected, including prevention and community-based supports, that there is a corresponding workforce capacity plan, and that an implementation plan includes clear lines of accountability and sustainable funding. Overall, the framework should reflect a long-term vision for dementia care in Ontario through identifying the needs over the next decade; otherwise, the framework will become obsolete by the time it is implemented.

AdvantAge Ontario is a willing and available partner in helping the province become the most dementia-friendly jurisdiction in Canada.

About Us

For more than 100 years, AdvantAge Ontario has been the voice of not-for-profit seniors' care in Ontario. We represent more than 540 providers of long-term care, seniors' housing, supportive housing, and community service agencies, including 96 per cent of all municipal long-term care homes and 88 per cent of all not-for-profit long-term care homes. We are the only association representing the full continuum of seniors' care in the province.

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References

1. Public Health Agency of Canada. (2019). *A dementia strategy for Canada: Together we aspire*. Government of Canada. <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/dementia-strategy.html>
2. World Health Organization. (2017). *Global action plan on the public health response to dementia 2017-2025*. World Health Organization. <https://www.who.int/publications/i/item/global-action-plan-on-the-public-health-response-to-dementia-2017-2025>
3. Alzheimer's Society. (2025). *Local dementia strategy toolkit*. Alzheimer's Society.
4. Alzheimer Society of Ontario. *Dementia-Ready Ontario* (2025).
5. Alzheimer Society of Canada. *Navigating the Path Forward for Dementia in Canada: The Landmark Study Report #1* (2022).
6. Alzheimer Society of Canada. *Dementia Numbers in Canada* (2024).
7. Livingston, G., Huntley, J., Liu, K. Y., Costafreda, S. G., Selbæk, G., Alladi, S., Ames, D., Banerjee, S., Burns, A., Brayne, C., Fox, N. C., Ferri, C. P., Gitlin, L. N., Howard, R., Kales, H. C., Kivimäki, M., Larson, E. B., Nakasujja, N., Rockwood, K., ... Mukadam, N. (2024). *Dementia prevention, intervention, and care: 2024 report of the Lancet Standing Commission*. The Lancet, 404(10452), 572-628. [https://doi.org/10.1016/S0140-6736\(24\)01296-0](https://doi.org/10.1016/S0140-6736(24)01296-0)
8. Canadian Institute for Health Information. (2025). *New long-term care residents who potentially could have been cared for at home*. CIHI. <https://www.cihi.ca/en/indicators/new-long-term-care-residents-who-potentially-could-have-been-cared-for-at-home>
9. Qureshi, T., Gallant, G., Bronstein, T., Hazelden, M., Brierley, A., & Sinha, S. (2026). *Perspectives on growing older in Canada: The 2025 NIA Ageing in Canada Survey*. National Institute on Ageing, Toronto Metropolitan University. <https://niageing.ca/reports/perspectives-on-growing-older-in-canada-the-2025-nia-ageing-in-canada-survey/>
10. Naber, J., Wibowo, A. S., Xu, J., Hilton, K., Beiser, A., Glymour, M. M., Amariglio, R. E., Rentz, D. M., Johnson, K. A., Jefferson, A. L., Au, R., & Haneuse, S. (2021). *Attributable fractions, overlap, and prevalence of modifiable Alzheimer's disease risk factors*. *Journal of Alzheimer's Disease*, 79(1), 29-38.
11. Canadian Institute for Health Information. (2018). *Palliative and end-of-life care*. *Canadian Institute for Health Information*. <https://www.cihi.ca/en/dementia-in-canada/spotlight-on-dementia-issues/palliative-and-end-of-life-care>

12. Public Health Agency of Canada, Neurological Health Charities Canada. (2014). Mapping connections: An understanding of neurological conditions in Canada - Chapter 2. Government of Canada. <http://www.phac-aspc.gc.ca/publicat/cd-mc/mc-ec/section-2-eng.php>.
13. Petrasek-MacDonald J, et al. (2018). Alzheimer's disease and related dementias in indigenous populations in Canada: Prevalence and risk factors. *National Collaborating Centre for Aboriginal Health*. <https://www.ccnsa-nccah.ca/docs/emerging/RPT-Alzheimer-Dementia-MacDonald-Ward-Halseth-EN.pdf>
14. Ontario Health. (2024). *Dementia: Care for people living in the community*. Ontario Health. <https://www.ontariohealth.ca/clinical/quality-standards/qs-details?cf=dementia>
15. Provincial Geriatrics Leadership Ontario. (2025). *Preparing Ontario's health care system for dementia care pathways*. Provincial Geriatrics Leadership Ontario. <https://geriatricsontario.ca/news/preparing-ontarios-health-care-system-for-dementia-care-pathways/>
16. Ismail, Z., Fischer, C. E., Pringsheim, T., Rej, S., Seitz, D. P., Alavi, N., Armstrong, M. J., Baerg, K., Barakat, C., Conn, D., Frank, C., Gnaedinger, N., Goodarzi, Z., Grinberg, A., Ismail, A., Lee, J., MacMaster, F. P., Marr, S., Mulsant, B. H., ... Canadian Coalition for Seniors' Mental Health. (2025). *The Canadian Coalition for Seniors' Mental Health Canadian clinical practice guidelines for assessing and managing behavioural and psychological symptoms of dementia (BPSD)*. *Canadian Geriatrics Journal*, 28(1). <https://doi.org/10.5770/cgj.28.844>
17. Alzheimer Society of Canada. (2011). *Guidelines for care: Person-centred care of people with dementia living in care homes framework*. Alzheimer Society of Canada. [https://alzheimer.ca/sites/default/files/documents/Guidelines-for-Care Alzheimer-Society-Canada.pdf](https://alzheimer.ca/sites/default/files/documents/Guidelines-for-Care_Alzheimer-Society-Canada.pdf)
18. Alzheimer's Association. (n.d.). *Dementia care practice recommendations*. https://www.alz.org/professionals/professional-providers/dementia_care_practice_recommendations
19. Fazio, S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The fundamentals of person-centered care for individuals with dementia. *The Gerontologist*, 58(Suppl. 1), S10-S19. <https://doi.org/10.1093/geront/gnx122>
20. National Institute for Health and Care Excellence. (2018). *Dementia: Assessment, management, and support for people living with dementia and their carers (NICE Guideline NG97)*. NICE. <https://www.nice.org.uk/guidance/ng97>