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From strategy to scale: a framework for operationalizing and evaluating dementia care coordination in Canada

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ABSTRACT – In 2019, Canada published its National Dementia Strategy (NDS). The NDS, along with the National Strategy for Alzheimer's and Dementia Act and numerous provincial reports, highlight the need for care coordination for people living with dementia (PLWD) and their care partners. Despite being identified as a priority, care coordination has been imprecisely operationalized and implemented. To address this gap, we sought to operationalize a clear definition of dementia care coordination that policymakers can use to assess programs. We created a Care Coordination Assessment Matrix and Scale to identify initiatives that incorporate core coordination components. This matrix was validated against federally funded programs that did not include care coordination as a primary assessment criterion, as well as provincially funded programs that explicitly prioritized coordination. Our findings demonstrate that dementia care coordination can be explicitly defined and assessed to inform policy and funding decisions.

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INTRODUCTION

The prevalence of dementia in Canada has reached unprecedented levels, driven primarily by the exponential growth of the country's older adult population (Alzheimer Society of Canada, 2022; Brainwell Institute, 2025). Dementia is a progressive neurodegenerative condition that evolves over an average of eight years, transforming daily life for people living with dementia (PLWD) and their care partners. As functional, cognitive, and psychosocial needs progressively decline, including driving cessation, financial and legal planning, medication and safety management, personal care, and continuous supervision, the demand on care partners grows (Cipriani et. al, 2020; Blazer et. al., 2015). Care partners therefore increasingly shoulder responsibility for broader functions such as coordinating care, monitoring functional and behavioural changes, and managing escalating safety risks (Canadian Institute for Health Information (CIHI), n.d.). Addressing these complex and evolving needs requires a shift away from episodic, reactive care toward deliberately structured, coordinated, and integrated support (Public Health Agency of Canada (PHAC), 2019a; Brainwell Institute, 2026).

Why coordination matters in dementia.

Canada's National Dementia Strategy (NDS), published in 2019, includes a dedicated Care pillar. The National Strategy for Alzheimer's and Dementia Act that underpins the strategy also identifies supporting provinces in improving system integration and care navigation as a key objective to enhance quality of care. (National Strategy for Alzheimer's Disease and Other Dementias Act, 2017; PHAC, 2019a). The *What We Heard: Informing a Dementia Strategy for Canada* engaged PLWD and care partners nationally who identified the urgent need for integrated and coordinated care and support for health system navigation for the PLWD (PHAC, 2019b). Multiple provincial dementia roundtables, reports and strategies, which all engage Canadians living with dementia to inform need, similarly highlight care coordination as a crucial underpinning to care requirements (British Columbia Ministry of Health, 2012; Government of Alberta, 2017; Government of New Brunswick, 2026; Government of Newfoundland and Labrador, 2023; Government of Nova Scotia, 2015; Government of Prince Edward Island, 2018; Guillette et al., 2021; Ontario Ministry for Seniors and Accessibility, 2022–2023; Ontario Ministry of Health and Long-Term Care, 2016). However, the concept of "care coordination" in dementia remains imprecisely operationalized and unevenly implemented across dementia care programs and health systems.

As the implementer of Canada's NDS, the PHAC funded over eighty-six projects and programs as of November 2024 to initiate action on dementia and build community capacity (PHAC, 2019a; 2024; 2026). Similarly, many provinces both with and without dementia strategies funded programs to support these objectives. Care coordination literature has identified the need for health system structures and processes that operate across individual, organizational, and system levels (Brainwell Institute, 2026; King et. al., 2024; McDonald et. al., 2007; PHAC, 2019a; PHAC, 2019b). Figure 1 provides an illustration of the complexity of the process, including the many sectors and programs that require coordination across the health and social systems. In addition to health system coordination across these sectors, interprofessional collaboration, effective information exchange, integrated care pathways, and community linkages are also needed to effectively meet the evolving needs of PLWD across the condition's trajectory (Brainwell Institute, 2026; PHAC, 2019; 2019; King et. al., 2024).

This emphasis on coordination is reinforced by pan-Canadian frameworks and standards. For example, both Healthcare Excellence Canada's Quality and Patient Safety Framework and the Health Standards Organization's Integrated People-Centered Health Services (IPCHS) Standard identify coordinated, people-centered approaches as foundational to delivering safe, high-quality care (Health Standards Organization, n.d.; Healthcare Excellence Canada, n.d.).

OBJECTIVES

Given the significant investments in dementia care programs at the federal and provincial level, we sought to operationalize a definition of dementia care coordination for three purposes: (a) to develop and validate a dementia specific Care Coordination Assessment Matrix with a scale to enable quicker assessment and decision-making, particularly for policymakers and (b) to assess for elements of care coordination in federally funded programs that would allow them to be ready for scale and integration through future funding of the NDS. The findings are intended to guide future funders and policymakers in assessing and investing in effective care-coordination initiatives.

METHODS

Defining care coordination

We adopt the definition developed by McDonald et. al., for the Agency for Healthcare Research and Quality (AHRQ): "*Care coordination is the deliberate organization of patient care activities among two or more participants (including the patient) involved in a patient's care, to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care*" (McDonald et. al., 2007). This definition emerged from a synthesis of more than forty prior definitions combining their shared elements (McDonald et. al., 2007).

Conceptual basis and operationalization of care coordination

To determine whether programs delivered components of care coordination, we developed a structured assessment matrix and accompanying scale to translate the concept into measurable and actionable elements (Appendix A). The Care Coordination Assessment Matrix and Scale assesses a program's readiness to provide effective coordination of care for PLWD by identifying existing coordination structures and processes, as well as highlighting gaps that may require attention prior to scaling or funding expansion.

Guided by the AHRQ conceptualization, the broad construct of *care coordination* was operationalized into eleven observable elements relevant to dementia care (Table 1). Table 1 outlines the conceptual domains and definitions, whereas Appendix A presents the applied scoring matrix used to evaluate programs against these elements.

To support consistent and practical scoring across diverse program types, we developed a four-point implementation scale ranging from *Start-Up* to *Well Established* (Appendix A). Sector-level scores were summed and rescaled to generate an overall coordination score out of sixteen, providing a standardized metric for comparing care coordination across programs. This scoring approach captures both the presence and functional maturity of coordination practices, enabling meaningful comparisons across programs with varying structures and levels of implementation.

Sampling and data

For the purposes of this assessment, a subset of programs funded through federal Dementia Community Investment (DCI) and Dementia Strategic Funds (DSF) were selected for review. Brief descriptions of all funded eighty-six programs (as of November 2024) were reviewed and initially coded for key themes such as awareness, education, engagement, and care coordination. Programs were screened by AA, LWC and RD for their potential for care coordination, particularly where programs were described as providing linkages across services, support for navigation, or system-level improvement even if not the primary objective of the program. Applying these criteria, fifteen programs were selected, of which publicly available deliverables were located for eleven programs (Appendix B):

1. Canadian Best Practice Guidance for Quality Community Supports and Care for Adults with Intellectual Disabilities and Dementia and Their Caregivers (DSF)
2. Reducing dementia-related stigma by using person-centered language to describe responsive behaviours in hospital admissions (DSF)
3. Online Dementia Guidance Resource Hub for Chinese Communities in Canada(DSF)
4. Stronger Together: Making Ottawa and Renfrew County Dementia Inclusive (DSF)
5. A Hub for Dementia and Awareness in New Brunswick (DSF)
6. Digital Dementia Resource for the Yukon (DSF)
7. Partnering for Dementia Friendly Communities (DSF)

8. Cultural Adaptation of MINT Memory Clinics: Improving Equitable Access to High-Quality Dementia Guidance for Older Canadians (DSF)
9. Cummings Centre Therapeutic Dementia Care Program (DCI)
10. Enhancing Minds in Motion as a Virtual Program Delivery Model for People Living with Dementia and their Care Partners (DCI)
11. Evaluating Co-designed Tools for Strong Partnerships in the Dementia Care Triad / Our Dementia Journey Journal (DCI)

To examine the construct validity of the Care Coordination Assessment Matrix and Scale, we purposively selected four provincially funded programs with established mandates in care coordination. These programs were chosen because their core objectives explicitly encompass coordination functions, including service navigation, inter-provider linkages, and system-level integration, positioning them as appropriate cases for validating the matrix.

These four programs were identified through a scoping verification process grounded in established principles for validating information in qualitative and grey-literature synthesis. First, targeted keyword searches (e.g., provincial dementia navigation) were conducted to identify relevant projects. Then, identified programs were cross-checked with primary sources to confirm project details and operational status. Information was triangulated across multiple independent sources to ensure reliability and mitigate bias. An iterative search process was used to identify any additional programs by reviewing relevant top search results.

These four programs comprised the purposive sample used for construct validation (for descriptions see Appendix C)

1. Provincial – First Link® Care Navigation (Provincial Alzheimer Societies)
2. Ontario – DREAM (Dementia Resource, Education, Advocacy, Mentorship)
3. New Brunswick – Navigating Dementia NB (Healthy Seniors)
4. Saskatchewan – RaDAR Rural Primary Care Memory Clinics

Scoring

Three reviewers (AA, RD and LWC) independently scored each project using the assessment scale to evaluate care coordination elements. The Care Coordination Assessment Matrix and Scale was piloted with three federally funded programs selected for convenience, and scoring discrepancies were reviewed to ensure consistency. Independent ratings were then calculated for the eleven federally funded programs and the four provincial programs. Scoring ranged from one to sixteen where a score of one indicated minimal or no care coordination and a score of sixteen indicated high coordination.

Inter-rater Reliability

Intra-class correlation coefficient (ICC) (Koo et. al., 2016) was used to assess the interrater reliability (IRR) among the three independent reviewers. The ICC was selected because ratings for each section of care coordination was measured on a four-point scale. ICC quantifies the proportion of total variance in ratings that is attributable to differences between subjects to provide a measure of consistency amongst raters using a scale from -1 to 1, with -1 indicating no reliability among raters and 1 indicating perfect reliability among raters.

RESULTS

Rating of Programs

Reliability coefficients showed that score patterns were generally stable across both federally and provincially funded programs. Federally funded programs produced an ICC of –0.41, indicating lower agreement among raters. This level of disagreement was anticipated, as care coordination was not a primary objective of these programs; raters therefore had to infer coordination elements that were not explicitly described, which naturally reduced reliability. In contrast, provincially funded programs demonstrated a higher ICC of 0.51, reflecting stronger rater agreement. Because these programs explicitly identified care coordination within their core objectives, raters were able to apply the Care Coordination Assessment Matrix and Scale as intended, resulting in greater consistency

and supporting the scale's construct validity. Overall, the contrast between federally and provincially funded programs (Figure 2) indicates that the matrix and scale effectively identify care coordination elements and can be applied reliably across diverse program contexts.

Federally Funded Project Assessment

The assessed federally funded programs appear to have demonstrated value in achieving their primary stated objectives, usually in raising awareness of dementia resources and improving knowledge. However, when evaluated using the Care Coordination Assessment Matrix and Scale, despite meeting an initial screen for potential care coordination elements, these programs scored lower across several domains of care coordination readiness (Figure 2).

Based on the Care Coordination Assessment Matrix and Scale, the eleven federally funded programs had an average total score of 5.79 out of 16 (36%) in support of care coordination (Figure 3). Scores reflected limited evidence of system-level integration, formalized coordination mechanisms, and continuity across care settings, all of which are essential elements of coordinated models of care.

Provincially Funded Program Assessment

In contrast, the four provincially funded programs were purposively sampled because they were known to include care coordination components as a mechanism to validate the Care Coordination Assessment Matrix and Scale. When assessed, these programs scored an average of 13 out of 16 (81%) in support of care coordination (Figure 3) and higher performance across all four domains of care coordination readiness (Figure 2). This reflected intentional project design, with care coordination embedded as a core and foundational component of project structure and operations. These results support the construct validity of the scale, demonstrating its ability to differentiate programs with well-developed coordination from those with more limited coordination elements.

See Appendix D for a full list of scores.

DISCUSSION

Operationalizing Care Coordination Using Assessment Scale

This study sought to operationalize a definition of dementia care coordination to better assess future dementia care initiatives. This operationalization was then applied to two types of initiatives: those explicitly designed to support care coordination and those without an explicit coordination focus, allowing for assessment of the validity of the scale.

As shown in Figure 3, the average score for federally funded programs was 5.79 out of 16 (36%), which suggests that most assessed federally funded programs have limited incorporation of care-coordination elements and were not explicitly designed to meet this need. This gap likely reflects the original intent of federal funding for education, awareness and surveillance, though care is a core pillar identified in the NDS. Many of the funded programs associated with that care pillar function primarily as information and resource hubs rather than as actively coordinated models or programs of care. While these supports are essential in the early stages of dementia and for care partners, they are insufficient for helping people navigate and coordinate care over the course of the condition.

In contrast, the four purposively sampled provincial programs scored substantially higher on the scale averaging 12.3 out of 16 (77%) as seen on Figure 3. When comparing average sector-level scale scores, provincial programs designed for care coordination showed markedly stronger performance in system integration, collaborative infrastructure, and foundational elements for coordinated care than the federally funded programs (Figure 2). This contrast further supports the scale's validity, providing it can differentiate between programs with varying degrees of care coordination.

Applying the Care Coordination Assessment Matrix and Scale to provincially funded programs provided validation of the tool for future project evaluation by revealing meaningful performance across the domains of care coordination.

Policy Implications for Dementia Program Design and Coordination

The Dementia Care Coordination Assessment Matrix and Scale provides a practical tool to support future dementia funding and grant program design. By operationalizing dementia care coordination, the scale can distinguish programs that primarily contribute to coordinated care from those that primarily focus on education, awareness or resource development. This clarity can help guide decisions on which programs should be funded, integrated or adapted to strengthen care coordination.

The results highlight an opportunity to build on existing federally-funded initiatives while strengthening their contribution to care coordination. While federal programs may have successfully provided education, surveillance, and resource development, care coordination was not considered a core component for their programs despite Care being a core pillar of the NDS. This is further reinformed by the National Strategy for Alzheimer's and Dementia Act (National Strategy for Alzheimer's Disease and Other Dementias Act, 2017) which directs the strategy to assist provinces by including greater integration of care as well as coordination. As a result, current federal initiatives meet their objective but have limited effect on improving continuity of care, navigation across services, or system integration. The power of federal investments into their programs can be strengthened by directing future funding to programs that support care coordination or supporting the scaling and integration of existing care coordination initiatives at the provincial level.

Investing in Proven Coordination Models

Care coordination plays a critical role in supporting PLWD and their care partners by organizing navigation, system linkages, and service integration across the continuum of care. Coordination-centered provincial programs demonstrate how these functions can be effectively structured and sustained, including in rural and resource-limited contexts. At the system level, coordinated approaches promote more efficient use of healthcare resources and facilitate smoother transitions between care settings. For care partners, clearly defined roles and responsibilities reduce caregiver burden and enable more collaborative decision-making (Niagara Health, 2025; ASO, 2025; Healthy Seniors Pilot Project (HSPP), 2024). Effective coordination also strengthens connections with community supports, enhances early recognition of changes in health status, and improves continuity of care beyond clinical encounters. Collectively, these features align with pan-Canadian quality and integrated care standards, underscoring care coordination as a foundational component of high-quality dementia care (Health Standards Organization, n.d.; Healthcare Excellence Canada, n.d.).

Evidence from Ontario and Saskatchewan demonstrates the feasibility and impact of interventions such as hospital emergency department embedded navigation and rural interprofessional memory clinics, with measurable benefits including the diversion of avoidable admissions, improved access, and enhanced care partner experiences (Niagara Health, 2025; ASO, 2025; ASO 2025; HSPP, 2024). Federal investments can strategically prioritize provinces or regions implementing such models, complementing its existing education and surveillance portfolios. Moreover, upcoming funding opportunities, such as the 2026 DCI programs, provide a timely opportunity to shift future funding rounds toward embedded care coordination capacity, building on proven provincial successes while extending the reach and sustainability of dementia care.

Strengths and Limitations

A key strength of this study is the development and use of an element-based matrix grounded in established care coordination definitions and Canadian frameworks, along with its application across a range of programs and projects. A primary limitation is the reliance on publicly available documentation, which may result in under-reporting of care coordination practices, alongside non-probabilistic sampling of provincial programs and a limited number of raters and programs.

CONCLUSION

Care coordination in dementia can be clearly defined, observed, and measured in ways that are meaningful for policy and funding decisions. Using an element-based matrix allowed us to distinguish awareness-oriented initiatives from coordination-centered programs, which demonstrate stronger system integration and continuity of care. To advance the quality-of-life goals and Care pillar outlined in the NDS, future investments should prioritize resourcing coordination capabilities such as navigation, interprofessional teams, shared care plans, and integrated care pathways alongside ongoing investments in education, awareness, and surveillance.

Figure 1 – Programs and sectors that require coordination for effective dementia care

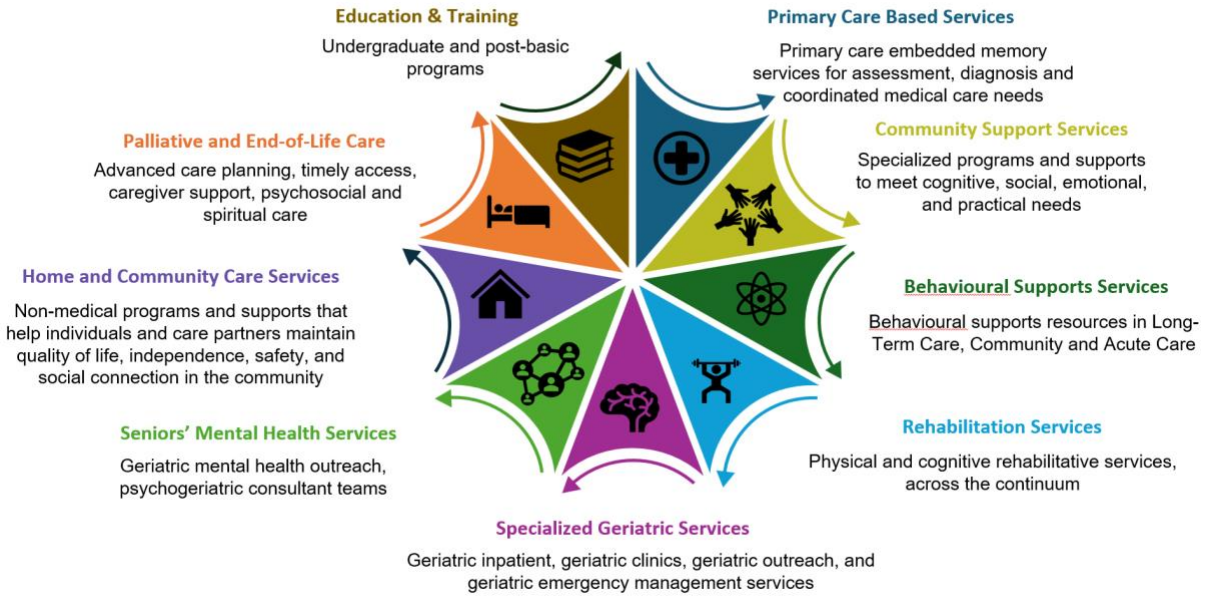

Figure 2 – Comparison of care coordination elements average assessment scores for federally and provincially funded programs

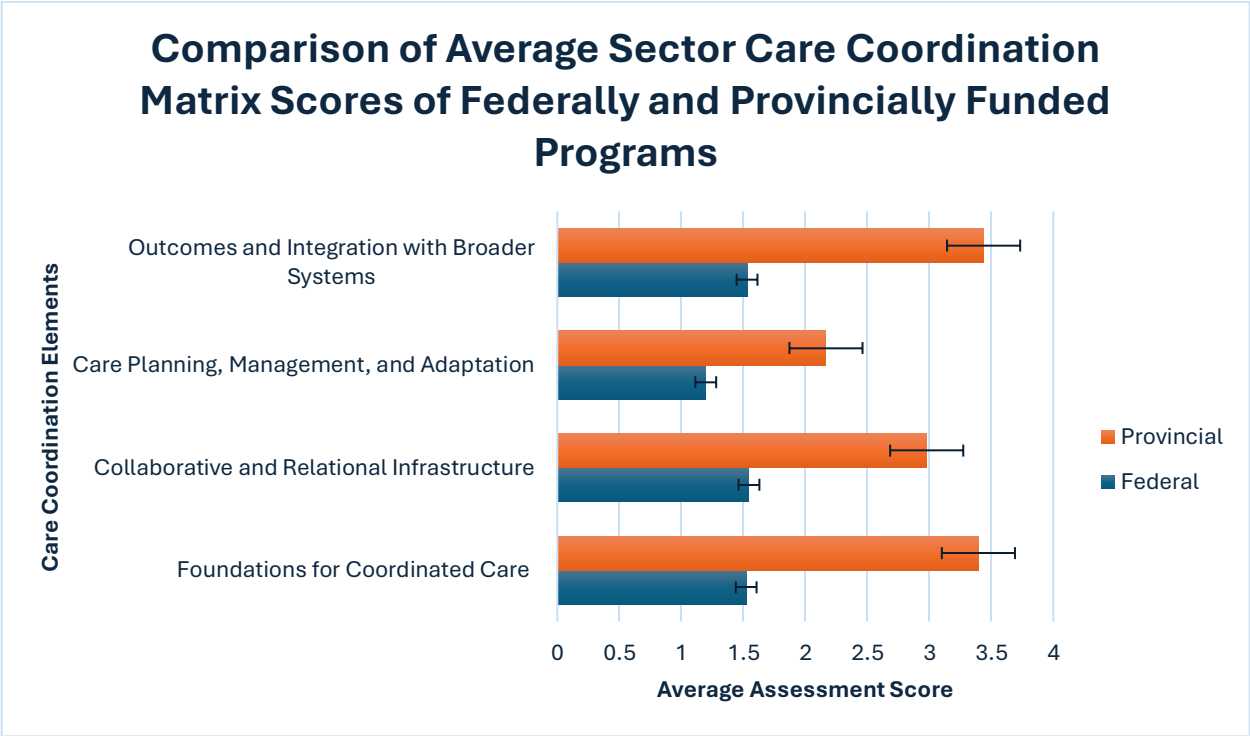

Figure 3 – Overall average care coordination score for federally and provincially funded programs

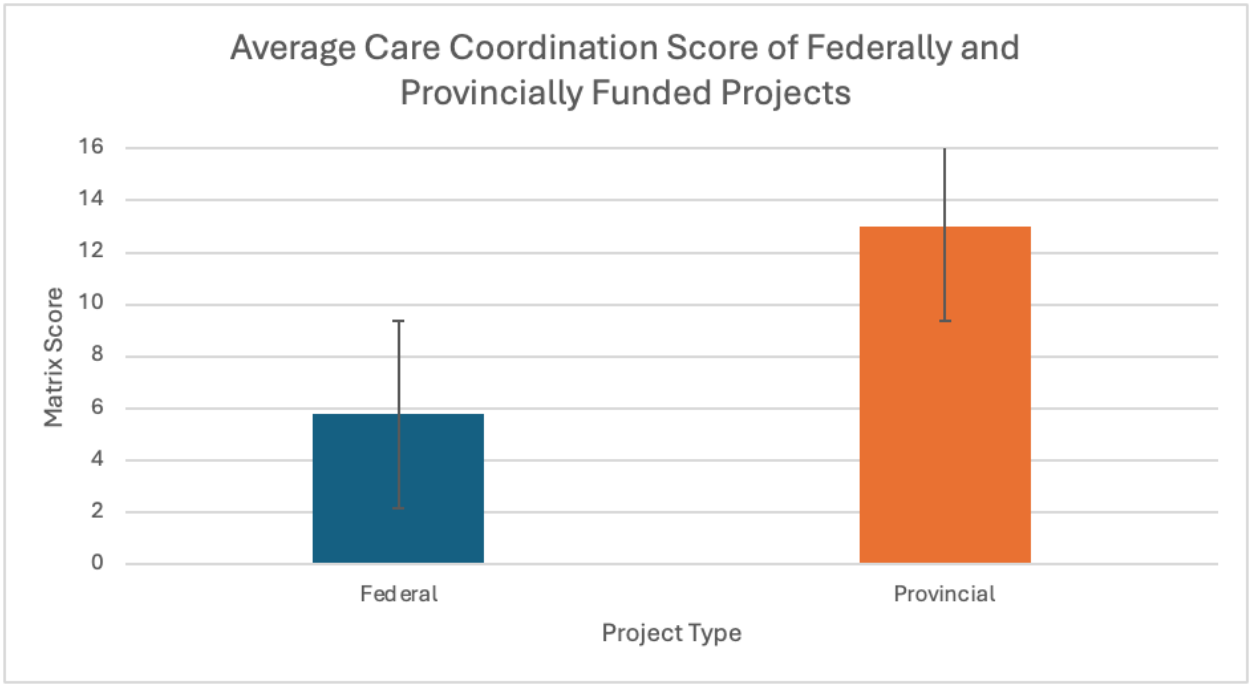

Table 1 – Description of observable elements of dementia care coordination

Observable Elements of Care Coordination		
Section 1: Foundations for Coordinated Care	Linking and Integrating Dementia Services	Mechanisms exist to connect and integrate care for PLWD and their care partners across settings and organizations; shared pathways or referral systems are operational; duplication or gaps are minimized.
	Dementia System and Organizational Integration	Organizational policies, data systems, and governance structures support coordinated care for PLWD and their care partners; coordination is embedded in strategic planning.
Section 2: Collaborative and Relational Infrastructure	Communication and Information Sharing	Clear and reliable channels for timely exchange of patient information; interoperable systems support communication among providers, patients, and families living with dementia.
	Collaborative, Team-Based Process	Multidisciplinary teams work collaboratively with defined roles; coordination responsibilities are clear; interprofessional respect and trust are evident.
	Patient - and Family Centered Approach	PLWD and care partners are actively engaged in care planning and decision-making; their goals and preferences inform service delivery.
Section 3: Care Planning, Management and Adaptation	Dementia Assessment and Planning	Comprehensive assessment and care planning across the dementia continuum are standard practice; plans are updated based on PLWD progress and evolving needs.
	Monitor and Follow - Up	Processes exist to track care delivery, outcomes, and PLWD progress; follow-up mechanisms are timely and responsive.
	Proactive Management and Navigation	The system anticipates PLWD and care partner needs, supports navigation across services, and prevents crises or fragmentation through proactive engagement.
Section 4: Outcomes and Integration with Broader Systems	Continuity Across Time and Settings	Systems and workflows ensure care transitions are smooth and well-documented; PLWD and care partners experience seamless dementia care across encounters and providers.
	Bridging Health and Dementia Social Supports	Coordination addresses not only clinical care but also social, emotional, and community support needs; partnerships with community organizations exist.
	Goal-Oriented and Outcome Focused	Care coordination efforts are guided by clear objectives and measurable outcomes; data is used to drive improvement and accountability.

APPENDIX A: CARE COORDINATION ASSESSMENT MATRIX AND SCALE

Readiness for Coordination of Care Assessment

Purpose: This tool helps assess how ready a project or program is to achieve effective coordination of care for people living with dementia. It identifies the elements of coordination already in place and highlights gaps to address before scaling or funding expansion.

Themes extracted from the 48 definitions:

Theme / Domain	Key Indicators of Readiness	Rating (1–4)	Evidence / Comments
1. Linking and Integrating Services	Mechanisms exist to connect and integrate care across settings and organizations; shared pathways or referral systems are operational; duplication or gaps are minimized.		
2. Communication and Information Sharing	Clear and reliable channels for timely exchange of patient information; interoperable systems support communication among providers, patients, and families.		
3. Patient- and Family-Centered Approach	Patients and families are actively engaged in care planning and decision-making; their goals and preferences inform service delivery.		
4. Collaborative, Team-Based Process	Multidisciplinary teams work collaboratively with defined roles; coordination responsibilities are clear; interprofessional respect and trust are evident.		
5. Continuity Across Time and Settings	Systems and workflows ensure care transitions are smooth and well-documented; patients experience seamless care across encounters and providers.		
6. Assessment and Planning	Comprehensive assessment and care planning are standard practice; plans are updated based on patient progress and evolving needs.		
7. Monitoring and Follow-Up	Processes exist to track care delivery, outcomes, and patient progress; follow-up mechanisms are timely and responsive.		
8. System and Organizational Integration	Organizational policies, data systems, and governance structures support coordinated care; coordination is embedded in strategic planning.		
9. Goal-Oriented and Outcome-Focused	Care coordination efforts are guided by clear objectives and measurable outcomes; data is used to drive improvement and accountability.		
10. Bridging Health and Social Supports	Coordination addresses not only clinical care but also social, emotional, and community support needs; partnerships with community organizations exist.		
11. Proactive Management and Navigation	The system anticipates patient needs, supports navigation across services, and prevents crises or fragmentation through proactive engagement.		

Section 1: Foundations for Coordinated Care

Element	4 – Well Established	3 – Developing	2 – Emerging	1 – Start-Up
Linking and Integrating Services	Comprehensive systems integrate care across settings; formal agreements, shared workflows, and interoperability are in place.	Integration occurs in some settings; partial service linkages established.	Pilot integration projects or informal coordination networks exist.	Services operate independently; no formal linkages or shared pathways.
System and Organizational Integration	Coordination embedded in governance, policies, and funding; shared records, standards, and leadership accountability.	Coordination supported by leadership and select systems but inconsistently applied.	Coordination recognized as a goal but lacks formal structures or accountability.	No formal structures or leadership mechanisms for coordination.

Overall Score:

Section 2: Collaborative and Relational Infrastructure

Element	4 – Well Established	3 – Developing	2 – Emerging	1 – Start-Up
Communication and Information Sharing	Robust, interoperable information systems; real-time exchange among all stakeholders.	Reliable but fragmented communication channels; partial interoperability.	Communication occurs via manual or informal processes.	Communication inconsistent or siloed.
Collaborative, Team-Based Process	Multidisciplinary teams with clear roles; strong trust, respect, and joint decision-making.	Teams collaborate but roles or workflows may overlap or vary across settings.	Some multidisciplinary collaboration; roles not clearly defined.	Providers work independently; no structured team processes.
Patient- and Family-Centered Approach	Patients and families actively co-design care plans and participate in governance.	Patients regularly engaged in care planning but not at governance level.	Patient input gathered intermittently or informally.	Care designed primarily by providers, with minimal patient/family input.

Overall Score:

Section 3: Care Planning, Management, and Adaptation

Element	4 – Well Established	3 – Developing	2 – Emerging	1 – Start-Up
Assessment and Planning	Comprehensive assessments and care plans updated regularly with patient and team input.	Standardized assessments conducted but not consistently updated.	Basic assessments exist; limited personalization or follow-up.	No systematic assessment or planning process.
Monitoring and Follow-Up	Consistent tracking of outcomes, adherence, and progress; feedback used to refine care.	Routine monitoring in some areas; follow-up processes vary.	Monitoring ad hoc or reactive; limited data used for improvement.	No formal monitoring or follow-up mechanisms.
Proactive Management and Navigation	Anticipatory planning and proactive outreach prevent crises and fragmentation.	Some proactive follow-up; limited anticipation of future needs.	Reactive response to issues as they arise.	No system for navigation or anticipatory management.

Overall Score:

Section 4: Outcomes and Integration with Broader Systems

Element	4 – Well Established	3 – Developing	2 – Emerging	1 – Start-Up
Continuity Across Time and Settings	Care transitions are seamless; information and accountability transfer clearly defined.	Transitions mostly smooth but with occasional lapses.	Transitions inconsistently managed; some duplication or gaps.	Fragmented care; transitions poorly coordinated.
Bridging Health and Social Supports	Strong partnerships with community, social, and public health services; social needs systematically addressed.	Some collaborations exist; referrals not fully integrated into workflows.	Informal or ad hoc connections to community supports.	No linkage between health care and social services.
Goal-Oriented and Outcome-Focused	Goals and outcomes clearly defined, measured, and aligned with patient priorities.	Goals identified but outcome tracking incomplete or inconsistent.	Goals documented but rarely linked to measurable outcomes.	No explicit goals or performance measurement for coordination.

Overall Score:

Scoring and Summary

Section	Overall Score (1–4)	Lowest Scoring Element(s)	Key Strengths / Gaps
1. Foundations for Coordinated Care			
2. Collaborative and Relational Infrastructure			
3. Care Planning, Management, and Adaptation			
4. Outcomes and Integration with Broader Systems			

Appendix B: Federally Funded Project Descriptions

Federal Programs	Program	Project Description
Canadian Best Practice Guidance for Quality Community Supports and Care for Adults with Intellectual Disabilities and Dementia and Their Caregivers	DSF	Intended to support planning and preparation for the creation of community-based dementia-capable supports and services for adults with intellectual disabilities across Canada. It is based on knowledge and feedback gathered from the Advisory Committee, focus groups, interviews, and a survey completed by disability, older adult and health organizations, as well as a scan of research and gray literature. The Guide reflects relationship-centered and person-centred care approaches, emphasizing the importance of relationships and the inclusion of adults with intellectual disabilities and dementia as active participants in planning for their future.
Reducing dementia-related stigma by using person-centred language to describe responsive behaviours in hospital admissions	DSF	This project developed and delivered a person-centred language education and coaching program for health professionals working in acute care settings to reduce stigma linked to behaviours, language, and practices, including how patients are described in verbal communication and written documentation. Guidelines were developed to support the implementation of person-centred language in various forms of communication used in care settings, such as progress notes, consult notes, and other areas within patient charts. By focusing on person-centred language to reduce the use of stigmatizing language, the project is improving the experience of patients who enter the health system in Toronto's Academic Health Science Network hospitals.
Online Dementia Guidance Resource Hub for Chinese Communities in Canada	DSF	The project team curated a comprehensive collection of information, tools, and support services tailored for Chinese communities to facilitate greater understanding and access to culturally appropriate dementia supports and resources. The project team hopes that this online hub will equip individuals with dementia, family caregivers, professionals, and the general public with the knowledge, skills, and strategies to live a fulfilling and positive life with dementia.
Stronger Together: Making Ottawa and Renfrew County Dementia Inclusive	DSF	This project has produced a step-by-step playbook to guide communities to become more dementia-inclusive that is informed by activities that took place in the Ottawa region. Also available are dementia-inclusive training modules tailored for the finance, retail, health and leisure sectors. These modules are free to access and offer strategies on approaching and communicating with a person living with dementia, as well as improving the inclusiveness of both indoor and outdoor environments. The project has expanded the Dementia 613 digital application which helps users locate businesses that are dementia-inclusive in the Ottawa and Renfrew County region by including additional businesses that completed the tailored training.
A Hub for Dementia and Awareness in New Brunswick	DSF	This project built a new online provincial hub for dementia education and awareness in New Brunswick. Dementia related topics on the hub include an overview of dementia, information related to living with dementia, planning for the future, community resources, risk reduction,

		and information for health care workers. A digital advertising campaign to raise awareness of this new education and awareness hub was developed and launched.
Digital Dementia Resource for the Yukon	DSF	A centralized, online hub to expand access to dementia information and resources was developed on the Government of Yukon's website (Yukon.ca). The hub was developed in consultation with subject matter experts, PLWD, caregivers, Indigenous representatives, health care practitioners and other relevant groups.
Partnering for Dementia Friendly Communities	DSF	The Partnering for Dementia Friendly Communities program funded by a $716,000 investment from the Governments of Canada and Newfoundland and Labrador supports eight diverse communities Clarenville Corner Brook Mary's Harbour Placentia Roddickton Bide Arm Springdale Stephenville and Twillingate in creating tailored dementia inclusive action plans. Led by the provincial government in partnership with Newfoundland and Labrador Health Services and the Alzheimer Society of Newfoundland and Labrador the initiative builds on the Dementia Care Action Plan to raise public awareness through social media mainstream media campaigns and a dedicated website DementiaFriendlyNL.ca. By reducing stigma, promoting understanding of dementia and fostering inclusive spaces where PLWD and their care partners can remain active and supported, the program improves quality of life and serves as a model for community-led change across the province.
Cultural Adaptation of MINT Memory Clinics: Improving Equitable Access to High-Quality Dementia Guidance for Older Canadians (Only Impact Report Available)	DSF	This project will improve access to and use of person-centered dementia guidance in primary care, with a focus on PLWD and dementia caregivers who face ethnic and cultural barriers to equitable dementia care. The project intends to adapt training and resources to meet the needs of several diverse populations in Alberta, British Columbia, New Brunswick, Nova Scotia, and Saskatchewan. Target populations will include South Asian, Indigenous and/or northern, and francophone communities.
Cummings Centre Therapeutic Dementia Care Program	DCI	Comprehensive and specialized day program for PLWD that includes support and respite services for care partners.
Enhancing Minds in Motion as a Virtual Program Delivery Model for People Living with Dementia and Their Care Partners	DCI	Minds in Motion® (MiM) began as an Alzheimer Society of Ontario pilot project in 2014. Now offered through local Alzheimer Societies across several Canadian provinces, this evidence-based program combines exercise, cognitive engagement, and social interaction for people living with early to mid-stage dementia and their care partners. This project is an extension of the existing in-person program, adapted to be offered virtually in English and French. A virtual approach broadened the program's reach by allowing participants to engage without the need to travel and avoided the impact of pandemic-related restrictions. PLWD and their care partners engage in the program together for 90-minute sessions once a week for eight weeks, conducted through Zoom.
Evaluating co-designed tools for strong partnerships in the dementia care triad (ODJJ)	DCI	The Our Dementia Journey Journal (ODJJ) is an interactive tool that was co-designed with and for PLWD, their family/friend caregivers, and their health care providers to help foster sustainable relationships between health care providers and family/friend caregivers by offering a safe space to connect, share and reflect. Allow the Circle of Care to (re)negotiate their respective roles as the circle and/or setting of care changes along the dementia journey.

Appendix C: Provincially Funded Project Descriptions

Provincial Programs	Project Description
Provincial – First Link® Care Navigation (Provincial Alzheimer Societies)	A referral and navigation program operating across provinces and territories that connects PLWDand their care partners to local supports and services through personalized, timely guidance (ASO, 2025).
Ontario – DREAM (Dementia Resource, Education, Advocacy, Mentorship)	Alzheimer Society consultants embedded in hospital emergency departments to divert non-acute presentations and link patients to community supports (Niagara Health, 2024).
New Brunswick – Navigating Dementia NB (Healthy Seniors)	A program guiding PLWD and their caregivers through health and social care systems to improve access and care experiences, using a pilot project of bilingual patient navigators (HSPP, 2024).
Saskatchewan – RaDAR Rural Primary Care Memory Clinics	Interprofessional assessment and post-diagnostic support integrated with provincial services and Alzheimer Society First Link program (Akwen et al. 2024).

Appendix D: Project Scores

	Reviewer Scores		
Project Type	LC	AA	RD
Federal Project 1	4	5	9.5
Federal Project 2	4	4.75	7
Federal Project 3	4	5	7.5
Federal Project 4	5	6	10
Federal Project 5	6	5.5	5.5
Federal Project 6	5	4.5	5.5
Federal Project 7	4	5.5	8.5
Federal Project 8	4	9.5	5.5
Federal Project 9	4	4	9.5
Federal Project 10	4	4	7.5
Federal Project 11	5	6	6.5
Provincial Project 1	15.5	15	11
Provincial Project 2	15	12.25	15
Provincial Project 3	6	10.75	13
Provincial Project 4	15	14	13.5

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