EXPERT ROUNDTABLE REPORT

Closing the Gap:
Strategies to Ready Canada's Health System for Alzheimer's Disease Treatments

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Executive Summary

Alzheimer's disease (AD) is entering a new era of treatment, with disease-modifying therapies (DMTs) offering the first evidence that progression of early-stage AD can be slowed. However, health systems in Canada are not yet prepared to deliver these complex therapies equitably and efficiently. To identify solutions, the Alzheimer Society of Ontario convened a multi-disciplinary roundtable of experts in dementia care and health systems, as well as people with lived experience. This report summarizes the key findings from those discussions and outlines actionable strategies to strengthen system readiness for DMTs.

Key Challenges to DMT Implementation

Six interrelated themes emerged as major barriers to readiness, with diagnostic delays and missing the therapeutic window for DMT eligibility as major negative outcomes. These include:

Data and Standardized Targets – Lack of national benchmarks, data monitoring, and performance tracking hinders accountability, planning, and advocacy efforts for funding.

Awareness and Attitudes – Persistent stigma and misconceptions about dementia among the public and healthcare providers delay help-seeking and referral to specialists, causing diagnostic delays.

Healthcare Provider Access, Capacity, and Training – Shortages of primary care physicians and specialists, as well as inadequate training, impede referral and early detection.

System Fragmentation and Complex Navigation – Disconnected care pathways, and limited understanding and support for patients and care partners in navigating the system, delay diagnosis and impact quality of care.

Access to Diagnostics and Biomarker Testing – Limited availability, funding, and infrastructure for diagnostic and biomarker tests—including cerebrospinal fluid (CSF) amyloid testing, amyloid positron emission tomography (PET), blood-based biomarkers, and magnetic resonance imaging (MRI)—restrict eligibility assessments for DMTs and challenge safe monitoring of patients on therapy.

Care Partner Support and Services – High care partner burden and lack of adequate support services—particularly in rural and underserved communities—contribute to inequities in care access.

Calls to Action

Roundtable discussions were summarized into nine priorities to enhance healthcare system readiness for DMTs:

1. **Launch a National Public Awareness Campaign**
   Increase understanding of early dementia symptoms, reduce stigma, and encourage timely help-seeking.

2. **Establish Measurable National Benchmarks and Robust Data-Monitoring Systems**
   Set targets for time to diagnosis and treatment initiation and implement data-monitoring systems to track and publicly report progress.

3. **Create Provincial Dementia Care Bodies**
   Establish branches within each province that oversee funding, standardized diagnostic pathways, and planning for dementia care.

4. **Expand Training for Primary-Care and Allied Health Professionals**
   Provide education on cognitive screening, biomarker use, referral pathways, and effective communication with patients.

5. **Increase Multidisciplinary Collaboration and Knowledge Exchange**
   Promote workshops and knowledge-exchange to share best practices across neurology, geriatrics, primary care, and allied health.

6. **Integrate Biomarker Diagnostics into Clinical Pathways**
   Publicly reimburse biomarker testing and build coordinated diagnostic workflows to accelerate eligibility evaluation for DMTs.

7. **Increase MRI and Amyloid-PET Imaging Capacity**
   Expand access to imaging, neuroradiology services, and training to meet diagnostic and monitoring needs for patients with DMTs.

8. **Support and Fund Care Partner Services**
   Provide respite care, navigation assistance, and care partner support to reduce burden and enable equitable access to treatment.

9. **Strengthen System Navigation**
   Introduce standardized referral pathways and increase funding for navigator roles to guide patients and families through the care pathway.

Purpose

Alzheimer's disease (AD) is entering a new era of treatment, with disease-modifying therapies (DMTs) offering the first opportunity to slow the progression of early symptomatic disease. However, health care systems in Canada are not yet adequately prepared for the implementation of these therapies. A critical component of this readiness gap is the lack of timely and accurate diagnosis of AD, which is essential for identifying eligible patients while treatment can still be effective. This challenge is particularly urgent, as approximately one-third of individuals with mild cognitive impairment (MCI) due to AD or mild AD dementia progress to the next stage within one year—at which point the benefit from amyloid-targeting DMTs significantly diminishes and patients may no longer be eligible for treatment.[1] This report summarizes the key barriers to integrating DMTs for AD in Canada and proposes solutions for enhancing healthcare system readiness, based on discussions from a meeting of experts in the field of aging and dementia and people with lived experience (see **Appendix A** for meeting participants and agenda).

Background

What is Dementia and Alzheimer's Disease?

Dementia is a term that covers a spectrum of progressive neurologic disorders that impair a person's cognitive abilities to a degree that it interferes with their daily life. Symptoms include changes in cognitive impairment in areas such as memory, reasoning, and language, as well as changes in mood and behaviour. Alzheimer's disease is the leading cause of dementia, accounting for approximately 60–70% of all cases.[2] It is characterized by the accumulation of abnormal proteins in the brain, called amyloid plaques and tau tangles, that disrupt communication between neurons, causing them to die.[3]

The Burden of Dementia in Canada

As of January 1, 2025, approximately 771,939 Canadians are living with dementia, and more than 414 new cases are diagnosed each day.[4,5] Projections indicate that by 2030 nearly 1 million Canadians will be affected, and by 2050 this number will surpass 1.7 million, with 685 new daily diagnoses expected.[4,5] Among seniors aged 65 and older, the current prevalence of AD is 8.7%, a figure anticipated to rise to 13.2% by 2050.[4,5] Dementia is projected to outpace other major chronic diseases in growth, with annual incidence in Canada expected to rise by roughly 50% from 2020 to 2040—surpassing the 40% increase anticipated for cancer.[4,6] This growth reflects the profound impact of an aging population and underscores the significant burden dementia will place on Canada's healthcare system. Importantly, women account for 62% of all diagnoses,[4] highlighting the disproportionate effect of AD and other dementias on women in Canada.

Dementia places a significant burden not only on those living with the disease but also on their care partners **(Box 1)**. For patients, the gradual decline in cognitive function and ability to perform daily tasks results in a progressive loss of independence and quality of life. For care partners—most often family members—the physical, emotional, and

financial demands are considerable. The Canadian Institute for Health Information reports that 45% of care partners for people living with dementia experience symptoms of distress, which is almost twice the rate observed among care partners of older adults with other health conditions (26%).[7] On average, care partners dedicate 26 hours per week to supporting a person with dementia, compared to 17 hours for other conditions.[7] Across Canada, this unpaid work amounts to more than 580 million hours annually, equivalent to about 290,000 full-time jobs and valued at nearly $10.3 billion (at the 2025 federal minimum wage of $17.75 per hour).[5] The majority of caregiving also falls to individuals under the age of 65 (88%), with significant consequences for labour force participation.[4] In 2020, caregiving for dementia was estimated to contribute to $21.8 billion in lost productivity due to absenteeism, presenteeism, and early retirement.[8]

The direct costs of dementia care are also substantial. The Canadian Centre for Economic Analysis estimated direct healthcare costs at $15.1 billion in 2020, driven largely by long-term care and hospital admissions in the later stages of disease.[8] These costs are projected to almost double by 2030. In addition, care partners shoulder a significant financial burden themselves. Out-of-pocket expenses, including home modifications, health services, aids, transportation, and medications, were estimated at $1.4 billion in 2020, with projections indicating this figure will exceed $3.8 billion by 2050.[8] Together, these figures highlight the immense personal, societal, and economic impact of dementia in Canada.

Box 1:

Impact of Dementia on Care Partners

In this report, a **Care Partner** refers to any individual who provides unpaid care services to support a person living with dementia. This is most often a family member or friend.

Care partners play an essential role in maintaining the dignity and independence of people living with dementia by assisting with their daily activities, ensuring safety and well-being, and allowing them to continue living within the community.[9]

Care partners may face significant physical, emotional, and financial burden associated with providing care to a person living with dementia, often to a larger degree than care partners supporting people with other chronic conditions.

(Box 1 continued)

Demographics of Care Partners in Canada[4,7]

90% providing dementia care in home are family members

54% are women

88% are <65 years old

Physical and Emotional Burden on Care Partners[7,10]

45% Proportion of care partners for people living with dementia who experience symptoms of distress vs. **26%** for care partners of older adults with other health conditions

21% Proportion of care partners who feel unable to continue their caring activities due to stress

>50% Proportion of care partners reporting impact on their own health as a result of caring responsibilities

Financial Burden on Care Partners in Canada[5,7,8]

26 Hours/ week Average time care partners dedicate to supporting a person living with dementia vs. **17 hours per week** for other conditions

$ 10.3 billion Annual value of unpaid work by care partners of people living with dementia

1.4 billion Estimated total out-of-pocket expenses for care partners in 2020

A Paradigm Shift: Disease-Modifying Therapies for Alzheimer's Disease

There is currently no known cure for AD and other dementias. Historically, treatments for AD have focused on managing symptoms. These therapies, such as cholinesterase inhibitors (e.g., donepezil) and N-methyl-D-aspartate (NMDA) receptor antagonists (e.g., memantine), can temporarily improve or stabilize cognitive function but do not address the underlying disease pathology or slow its progression.

The treatment landscape, however, is shifting with the emergence of disease-modifying therapies (DMTs). These innovative therapies—largely monoclonal antibodies designed to reduce amyloid-β plaques in the brain—have demonstrated in clinical trials that they can slow cognitive and functional decline in individuals with early-stage AD.[11] For instance, trial results for lecanemab (FDA-approved in June 2023) and donanemab (FDA-approved in July 2024) showed measurable reductions in the rate of decline compared with placebo in patients with mild cognitive impairment or early AD.[12,13]

Regulatory approvals have already enabled the rollout of DMTs for AD in all G7 nations, including Canada, which was the last G7 nation to approve a DMT on October 25, 2025. With a robust pipeline of additional DMTs in development and one additional DMT being reviewed by Health Canada, the availability of these therapies in Canada is imminent. However, their introduction will present significant challenges across Canada. Unlike symptomatic therapies, DMT eligibility is restricted to individuals in the early stages of AD **(Box 2)**, defined by cognitive test scores and confirmation of amyloid pathology through biomarker testing.

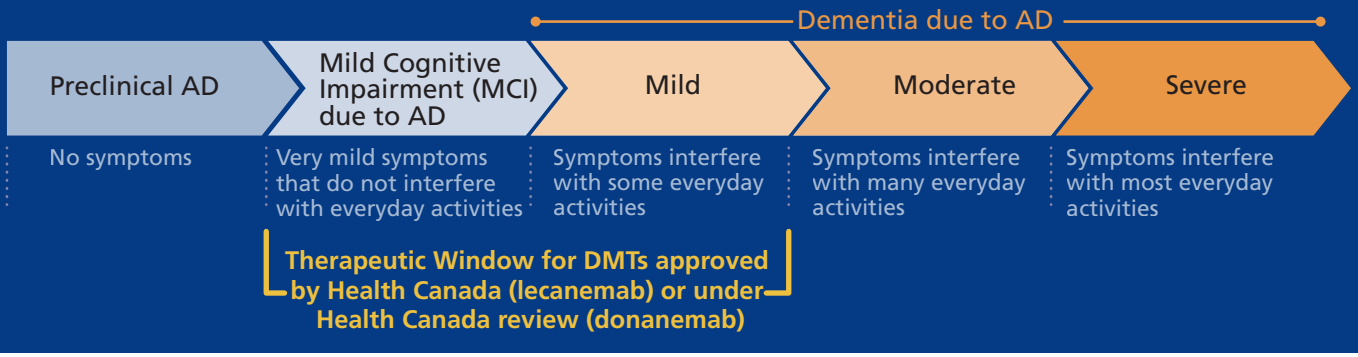
Box 2:

Stages of Alzheimer's Disease and the Therapeutic Window

Amyloid aggregation—a biological hallmark of AD—can accumulate in the brain up to 20 years before symptoms appear, silently damaging neurons and disrupting communication between brain cells.[16,17]

As the disease progresses, individuals move from preclinical (no outward symptoms) to mild cognitive impairment (MCI), a stage marked by subtle memory lapses or difficulty with complex tasks that do not yet significantly affect daily function. Eventually, cognitive decline advances to mild, moderate, and severe dementia, when symptoms increasingly interfere with independence and daily life.

Current amyloid-targeting DMTs are most effective when initiated during the MCI or mild dementia stage, when there is still enough healthy brain tissue to preserve function. Early diagnosis provides the opportunity to initiate therapy within this therapeutic window.



In addition, treatment requires ongoing monitoring with magnetic resonance imaging (MRI) to detect and manage potential side effects such as amyloid-related imaging abnormalities (ARIA, **Box 3**). These requirements demand diagnostic capacity to identify eligible patients in the therapeutic time window, specialized infrastructure, and streamlined referral pathways. The conversation around system readiness for DMTs in Canada has already begun, with the Canadian Drug Agency (CDA-AMC, formerly the Canadian Agency for Drugs and Technologies in Health [CADTH]) identifying these elements as critical gaps within the current healthcare system.[14] Without deliberate planning, the system will struggle to meet the anticipated demand for timely diagnosis, treatment, and monitoring.[15]

Box 3:

Understanding Amyloid-Related Imaging Abnormalities (ARIA)[18,19]

What is ARIA?

Amyloid-related imaging abnormalities or ARIA are a side effect of amyloid-targeting DMTs for AD that reflect temporary changes in brain blood vessels as amyloid plaques are cleared.

Types of ARIA include:

- **ARIA-E:** Edema or effusion — swelling or fluid buildup in the brain.
- **ARIA-H:** Microhemorrhages or superficial siderosis — small areas of bleeding.

How is ARIA detected?

- Only through magnetic resonance imaging (MRI).
- Requires baseline MRI before treatment and repeat scans during therapy (typically at 3, 6, and 12 months).

How common is ARIA?

- Detected in 12–35% of patients receiving amyloid-targeting DMTs.
- Most cases are mild or asymptomatic and resolve spontaneously over weeks to months.
- Symptomatic ARIA occurs in roughly 3–7% of treated patients.

What are the consequences of ARIA?

- Severe ARIA can lead to neurological symptoms such as confusion, disorientation, headache, visual disturbances, nausea, or seizures.
- In rare cases, it may cause extensive cerebral edema or bleeding, leading to hospitalization or, very rarely, permanent neurological deficits.
- Because of these potential complications, treatment interruption or permanent discontinuation of the DMT may be required.

Who is most at risk?

- Individuals carrying the APOE ε4 allele, those receiving higher treatment dosage, and those with the presence of any microhemorrhage on baseline MRI have a higher likelihood of developing ARIA

Why does ARIA make DMTs challenging to implement?

- DMT delivery depends on access to timely MRI scans for monitoring.
- Requires radiology capacity and education, specialist coordination, and management protocols.
- Limited MRI availability across regions may delay treatment or compromise safety oversight.

Preparing for a New Era of Treatment

The shift from symptomatic therapies to treatments that alter the course of the disease represents a new era in Alzheimer's care. To ensure Canadians have equitable and timely access to DMTs, a strategic and coordinated national approach is urgently needed from health systems across the country.

To help address this, an expert advisory group was convened with the goal of exploring barriers to implementation of DMTs and identifying solutions to strengthen system readiness in Canada at a roundtable meeting on July 29, 2025 in Toronto. The discussions focused on prioritizing actionable strategies to transform the AD care pathway and equip Canada's healthcare system for this next stage in dementia care.

Methodology

An expert advisory group was organized by the Alzheimer Society of Ontario (ASO) (See **Appendix A**, Table 1 and 2 for a full list of participants and observers). Members of the Ontario Dementia Care Alliance (ODCA), another expert advisory group facilitated by ASO, were invited by email with the goal of achieving a balance of clinicians, system (administrative) leaders, and people with lived experience to attend the roundtable. The goal of the advisory group was to define barriers to the successful implementation of DMTs for AD and, more importantly, to develop actionable solutions to boost system readiness for DMTs in Canada. A 90-minute in-person roundtable meeting took place on Tuesday July 29th, 2025, held in Toronto, Ontario, funded by ASO industry partner Lilly Canada (See **Appendix A**, Table 3 for meeting agenda). Participants also provided feedback through pre- and post-meeting surveys. Qualitative analysis of the roundtable discussion was used to group takeaways into key themes for the development of this report. Survey responses were analyzed and presented using descriptive statistics. This white paper was developed by the authors as a culmination of these findings, with participants reviewing the final document to ensure accuracy and alignment with the meeting discussions.

Results

Gaps in the Healthcare System and Barriers to Implementing DMTs

Participant Insights

Participants were invited to share their perspectives on the most urgent healthcare system gaps that create barriers to implementing DMTs for AD.

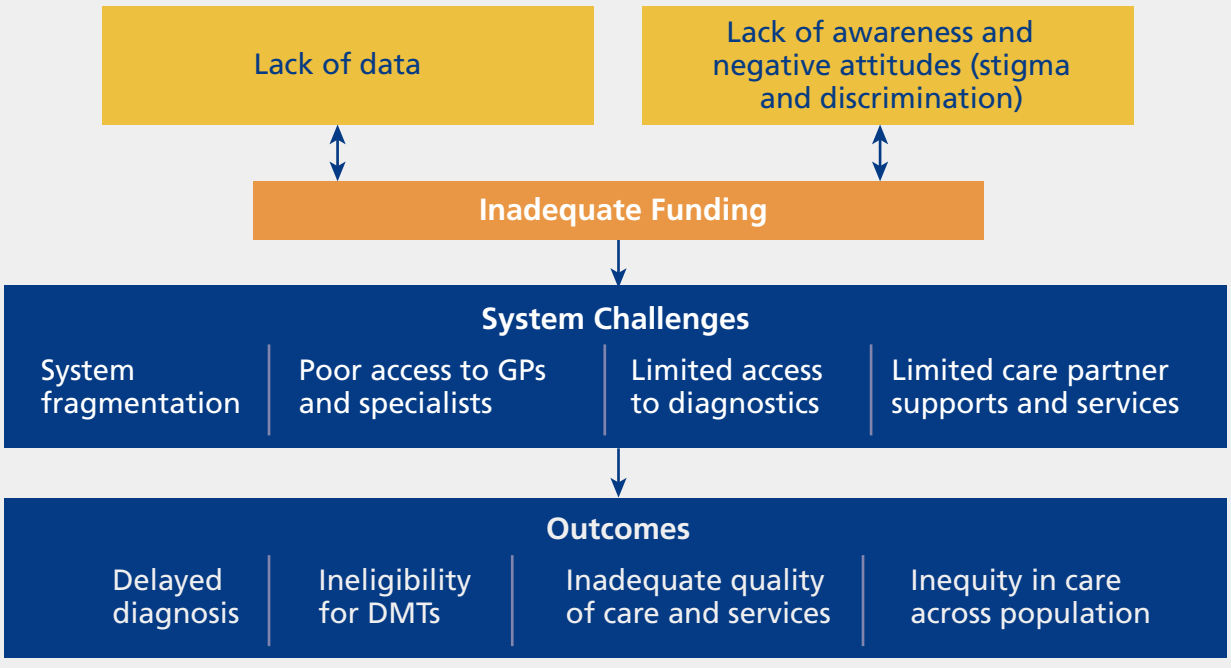
Pre-meeting survey results (Appendix B, Questions 1 and 2):

- Low recognition of early symptoms was identified as a barrier by 8 of 14 respondents.
- Limited access to healthcare providers (HCPs) was cited by 7 of 14 respondents.
- Among the 7 participants with lived experience, long wait times to see a specialist for diagnosis emerged as a universal concern.

Roundtable discussion:

- During the meeting, participants explored initial findings in depth and identified additional system-level barriers.
- While challenges related to patient monitoring on treatment were noted—such as limited MRI access and specialist availability to interpret scans—**the greatest emphasis was placed on barriers to timely and accurate diagnosis.**
- Participants emphasized that healthcare system barriers are highly interconnected and tend to compound one another rather than occur independently.
- Inadequate and inconsistent funding was repeatedly cited as a *root* challenge, contributing to delayed diagnosis, unequal access to care, and limited services and supports for patients and care partners **(Figure 1)**.

Figure 1. Barriers and system challenges for implementation of DMTs



Importance of Early Diagnosis

Early diagnosis of AD is essential because it:

- **Determines treatment eligibility:** Patients must be diagnosed early to qualify for DMTs.
- **Supports informed decision-making:** Early diagnosis enables patients to participate meaningfully in care planning and risk-benefit decisions while they retain cognitive capacity.
- **Facilitates life planning:** It gives patients and care partners time to arrange supports, access community resources, and plan for future care needs.

Despite these benefits, diagnosis is often delayed. A systematic review and meta-analysis published in 2025 estimated **the average time from symptom onset to a formal dementia diagnosis is 3.5 years.**[20] Factors contributing to delayed diagnosis vary by study, but may include: young-onset dementia (<65 years), increasing age of onset (e.g. >85 years), depressive symptoms, belonging to an equity-deserving group, having a lower-income, having a lower-education, having better cognition at dementia onset, and having less common dementias.[21-24] These delays create inequities in quality of care and potential access to treatment, a concern echoed in national and provincial dementia strategies and other global policy documents that call for earlier, more equitable diagnosis.[25-32]

Priority Challenges Requiring Coordinated Action

The roundtable identified six major areas that must be addressed to improve system readiness for DMTs:

- **Data acquisition and standardized targets**
- **Awareness and attitudes**
- **HCP access, capacity, and training**
- **System fragmentation and complex navigation**
- **Access to diagnostics and biomarker testing**
- **Care partner support and services**

Key messages and supportive evidence for the presence of barriers to DMT readiness are described below.

Data acquisition and standardized targets

The limited capture of data on diagnostic pathways and timelines in Canada is a fundamental barrier to implementing strategies to enhance system readiness for DMTs. Without reliable, system-wide measurement, it is difficult to identify inefficiencies, establish accurate baselines, or monitor progress—making it nearly impossible to set or enforce benchmarks for timely diagnosis and treatment.

International examples demonstrate the power of measurement to drive improvement:

- In Australia, the first annual report from the Australian Dementia Network Registry found that more than 40% of people waited over three months to see a dementia specialist after GP referral.[33] Using this baseline, the Australian Government's National Dementia Action Plan set a goal to increase the proportion of people assessed within the three-month timeframe, which will be tracked through a public indicators dashboard to ensure transparency and accountability.[34]
- England's *Dementia Care Pathway Implementation Guide* likewise established a six-week target for diagnosis and treatment initiation from referral.[35] Data from a National Audit of Dementia revealed that the average wait from referral to specialist assessment rose from 13 weeks in 2019 to 21.6 weeks (151 days) in 2023.[36] The audit also found a wide range of wait times (44 to 347 days), with two services meeting the six-week diagnosis target for more than half of their patients, while 32 services were unable to meet this target for any patients.[36] Analysis using the Index of Multiple Deprivation found that people in the most deprived areas waited about 15 days longer to receive a diagnosis than those in the least deprived areas.[36]

These experiences show that transparent measurement can create accountability and expose regional variation and inequities, giving policymakers, funders, and providers the information needed to evaluate performance, allocate resources, and drive continuous improvement. The government of Canada has outlined some plans for data acquisition and surveillance in their national dementia strategy,[26] but it is unclear whether data on diagnostic timelines will be captured and whether it will be accessible to the public. The ASO is also prioritizing data collection with the launch of a dementia registry in partnership with the Ontario Brain Institute but this project remains in its pilot stage covering only 4 underserved regions. Currently, without national and provincial data and established targets, Canada lacks the visibility and leverage required to ensure timely and equitable diagnosis and access to DMTs.

Awareness and attitudes

Low awareness of dementia symptoms and available treatments among both the public and HCPs continues to delay early detection. A 2023 Public Health Agency of Canada (PHAC) survey found that only 28% of Canadians consider themselves knowledgeable about dementia.[37] This limited understanding fuels the misconception that dementia is a normal part of aging and fosters negative attitudes toward early diagnosis and care planning—an implicit "why bother" mindset.

These attitudes are more pronounced in some communities. In a 2020 PHAC survey, 34% of Black respondents, 28% of South American respondents, and 27% of South/Southeast Asian respondents believed the misconception that dementia is inevitable with aging, compared with 16% of Canadians overall.[38] Such beliefs delay help-seeking as early symptoms are dismissed as "just getting older," thus undermining equitable access to timely care.

Fear of the diagnosis itself and stigma are also deterrents to seeking care. Based on the 2023 PHAC survey[37,39]:

63% of Canadians worry about developing dementia

Top concerns of developing dementia were:

- Loss of independence (93%)
- Becoming a burden (92%)
- Loss of self (89%)

68% of Canadians say they would be very comfortable asking a health care provider for information about dementia symptoms leading to an assessment and diagnosis

Of those who were not comfortable seeking help, the most common reasons included:

- Fear of what lies ahead (75%)
- Fear of being treated differently (56%)
- A lack of trust that the health care system will provide proper care (47%)
- Fear of alarming those close to them (46%)

83% of Canadians agree that people make negative assumptions about the abilities of those living with dementia

28% of Canadians feel their community is knowledgeable and respectful of those living with dementia

Knowledge gaps and attitudes among physicians compound the challenge. The *World Alzheimer Report 2021* found that globally one-third of HCPs viewed diagnosis as futile because "nothing can be done".[40] While Canadian-specific data were not reported, these concerns were voiced by roundtable participants suggesting that negative attitudes on dementia diagnosis also likely influences Canadian practice.

Ageist perspectives and the low prioritization of older adults among some leaders and policy makers further dampen investment in dementia planning. Where dementia is not treated as a policy priority, there is less motivation to fund public education, primary-care training, culturally tailored outreach, and the system changes needed to identify and diagnose people early.

For these reasons, raising awareness and reducing stigma are key pillars of dementia action plans worldwide. According to the WHO *Global Status Report on the Public Health Response to Dementia*, about two-thirds of reporting countries have launched public awareness campaigns, including Canada.[41] Yet participants in the roundtable noted that national coverage and measurable impact remain limited particularly in equity-deserving populations, underscoring the need for sustained and more targeted efforts.

It is important to recognize Indigenous Peoples in Canada as an equity-deserving population with unique perspectives on aging, memory, and cognitive change. In many Indigenous languages, there is no direct translation for the word *dementia*, and memory loss is often viewed as a natural part of the circle of life.[10] These beliefs are deeply rooted in Indigenous science, spirituality, and culture and fosters greater acceptance of the condition and compassion toward affected individuals within communities.

Thus, to support culturally safe and effective education efforts, it is essential to understand the diverse beliefs, experiences, and concerns of Indigenous communities regarding dementia. Awareness initiatives should therefore be co-developed with Indigenous partners, respecting traditional knowledge systems and communication approaches. This collaborative approach, which is applicable across all equity-deserving communities, can help bridge perspectives, promote trust, and ensure that education and awareness campaigns are both meaningful and respectful.

Healthcare professional access, capacity, and training

Canada faces a well-documented shortage of family physicians, limiting access to what is often the first point of contact for those presenting with cognitive concerns. The College of Family Physicians of Canada reports that workforce supply is not keeping pace with rising demand. In a 2022 position statement, they note that even before the COVID-19 pandemic, almost 5 million Canadians lacked a regular primary care provider and that growth in family-physician supply has slowed, particularly in remote areas.[42]

Specialist shortages are also a reality in Canada. Meeting participants highlighted the limited number of neurologists, geriatricians, and geriatric psychiatrists who can provide comprehensive dementia assessments. National data support these concerns, with one Canadian study reporting a shortage of 471.7 full-time equivalent geriatricians in 2019 based on a benchmark ratio of 1.25 specialists/10,000 population over 65.[43] This shortage is expected to grow to 587 by 2030. Similarly, the number of practicing neurologists is insufficient in Canada, with many provinces falling below the average for high-income countries, and access remains especially low outside of urban centres.[44]

"7 of 10 HCPs felt that current guidance for imaging and biomarker testing to diagnose AD were not well understood by clinicians."

Training gaps are also a significant barrier to timely diagnosis of AD. The *2021 World Alzheimer Report* found that 37% of clinicians cited lack of knowledge as a key barrier to diagnosis.[40] In our own pre-meeting survey, 7 of 10 HCPs felt that current guidance for imaging and biomarker testing to diagnose AD were not well understood by clinicians (**Appendix B**, Question 3). Experts also cited training gaps including inadequate experience or comfort with performing lumbar punctures (required to gather cerebrospinal fluid [CSF] for diagnostic testing), as well as insufficient knowledge of how to read amyloid PET scans to diagnose AD and MRI scans to detect ARIA.

Even when physicians are trained and available, both family doctors and specialists face heavy workloads which creates tension over who should "own" the diagnostic process.

On one hand, with primary care physicians leading diagnostic assessment, this could speed access and leverage existing relationships. However, many feel specialists should be involved to ensure diagnostic accuracy, particularly for emerging DMTs. Memory clinics led by multidisciplinary teams (MDTs) have demonstrated improvement in diagnostic efficiency and workload balance, both in Canadian case examples and abroad.[45-47] These teams typically include primary care physicians and specialist oversight with the addition of allied health professionals. In addition to accelerating diagnosis by relieving physician workload, MDTs that include nurses, clinical pharmacists, and social workers can enhance patient and care partner satisfaction, help manage comorbidities, support advance care planning, and improve coordination of community resources. Unfortunately, participants felt there was a significant lack of funding for these roles in Canada.

Together, these shortages, knowledge gaps, and unclear diagnostic responsibilities delay recognition of AD and limit access to emerging treatments. Strengthening and funding multidisciplinary memory care, clarifying referral pathways, and expanding funding and training opportunities for both physicians and allied professionals are critical steps toward a more efficient and equitable diagnostic system.

System fragmentation and complex navigation

System fragmentation and complex navigation significantly impede patient and care partner journeys toward diagnosis and treatment. One core issue is the absence of standardized referral or diagnostic pathways within each province. Without such consistency, patients are often left confused about whom to contact and when. The roundtable emphasized that system navigation can be particularly complex for those in rural areas, those without a care partner, those with lower education, or those whose first language is not English or French, resulting in delays and inequities in care.

The absence of consistent interprofessional collaboration and MDTs exacerbates navigation challenges. Memory clinics and collaborative care models help alleviate these challenges by creating centralized points of assessment and follow-up, but access to these clinics is not uniformly available. In rural primary health care memory clinics, embedding a navigator role (such as an Alzheimer Society First Link Coordinator) has been shown to help patients and care partners understand and connect with the services that are available to them.[48] Funding to expand and sustain these types of models that aid in system navigation are needed to allow equitable access to diagnosis and care, particularly as these needs increase with the introduction of DMTs.

Interior Health in British Columbia has embarked on an effort to improve system navigation through a *"Phased Dementia Pathway"* that provides resources for providers and care partners through different stages of dementia; however, plans to ensure implementation of these tools are lacking.[49] In order to aid system navigation and the improvement of care for all patients living with dementia, the Alzheimer Society of Ontario's *ODCA 2025 Recommendations* call for the establishment of a central infrastructure in Ontario tasked with coordinating funding, measurement, oversight, and implementation of a dementia care system with standardized diagnostic pathways.[50] Such infrastructure can help to clarify roles, establish expectations, and reduce variation in care. The Brainwell Institute's "Mind the Gap" report outlines the case for an agency model based on previous successes in Canada with cancer and stroke care.[51]

"In rural primary health care memory clinics, embedding a navigator role has been shown to help patients and care partners understand and connect with the services that are available to them."[48]

There is also a lack of electronic medical record (EMR) connectivity and interoperability between systems in Canada, which contributes to fragmentation.[52] When patient information is siloed across different clinics and providers, critical details like past assessment results, imaging, and medications may not be shared, potentially leading to unnecessary repetition of testing, delayed referrals, or missed opportunities to detect cognitive decline early.

Access to diagnostics and biomarker testing

Recommendations for appropriate use of DMTs, including medicines like lecanemab and donanemab, suggest that potential candidates for therapy be assessed across multiple domains.[53,54] First, a clinical diagnosis of mild cognitive impairment or mild AD must be made. This typically involves a detailed history of symptoms and their impact on activities of daily living, a medication review and routine laboratory tests to rule out reversible causes of cognitive decline, and cognitive testing—most commonly the Mini-Mental State Examination (MMSE) or Montreal Cognitive Assessment (MoCA), though use varies across practice.

To confirm AD pathology, a biological diagnosis is also necessary based on updated National Institute on Aging and Alzheimer's Association 2024 criteria.[55] This entails detection of amyloid and tau biomarkers via CSF analysis or amyloid/tau positron emission tomography (PET). Although both biomarker modalities are approved by Health Canada, access remains limited outside of research programs. PET imaging is further constrained by long wait times and the logistical challenges of timely radiotracer availability. A horizon scan published by CADTH (now the CDA-AMC) in 2022 noted that most patients do not currently receive confirmatory biomarker testing,[56] creating significant inequities.

Blood-based biomarkers have transformed diagnostic testing in other diseases, such as cancer, by improving accessibility, affordability, and turnaround time.[57,58] In AD, plasma biomarkers such as the beta-amyloid 42/40 (Aβ42/40) ratio and phosphorylated tau217 (p-tau217) have demonstrated strong concordance with more invasive amyloid detection methods, including CSF analysis and PET imaging.[59] These blood-based tests could offer a non-invasive, cost-effective, and patient-friendly alternative to current diagnostic approaches; however, they are currently only available in some provinces and are not publicly funded. As research on new blood-based biomarkers continues, plans on how these tests can be integrated into diagnostic pathways should be made proactively to ensure they are available as soon as evidence supports their clinical use. This includes training for physicians on how to interpret blood-based biomarker test results.

Canada must be prepared for the increased demand for MRI scans that are needed to safely and effectively deliver DMTs. A baseline MRI scan will be needed within 12 months of treatment initiation to rule out structural evidence of non-AD pathology that may be contributing to cognitive symptoms, as well as to detect evidence of hemorrhages that increase the risk for developing ARIA. Ongoing MRI surveillance is also required during therapy to monitor for ARIA. With Canada having fewer MRI machines per capita than the majority of other countries in the Organisation for Economic Co-operation and Development,[60] and interpretation of ARIA with MRI requiring neuroradiological expertise that is in short supply, MRI capacity and personnel training is an urgent unmet need that must be addressed.

Finally, genotyping of the apolipoprotein E (APOE) gene, the most common gene linked to late-onset AD, is advised before starting DMTs because APOE ε4 carrier status strongly predicts ARIA risk.[18] At present, this testing is rarely publicly funded, leaving many patients to pay out of pocket or rely on private insurance or institutional programs, which further widens disparities in access and impedes shared decision-making between clinicians, patients, and care partners on the benefits and risks of DMTs.

Delays in getting any of these diagnostic or biomarker tests can increase the chance of pushing the patient beyond the therapeutic window for DMTs. Thus a national approach to delivering equitable and timely access to each of these diagnostic steps will be critical if Canada is to realize the potential benefits of DMTs and avoid deepening existing gaps in dementia care.

Care partner support and services

Family and friend care partners play a critical role in supporting people living with dementia, even in the early stages of disease. Many individuals with mild cognitive impairment or mild dementia cannot reliably manage transportation, scheduling, or consent without an engaged care partner. Since determining eligibility for DMTs involves multiple interactions with the health system, and treatment protocols require ongoing assessments, care partner capacity is essential for both access to and adherence with DMTs.

The demands on care partners can create significant inequities. For example, those in rural communities face added travel time and fewer available day programs and support services.[61] Language barriers can also reduce access to education and support groups.[62,63] Patients lacking a consistent care partner may simply be excluded from treatment programs, creating disparities that contradict the goal of broad therapeutic access.

Without substantial investment in care partner supports, such as funded respite care, timely access to day programs, and policies that integrate care partners into diagnostic and treatment pathways, Canada will face major barriers to safely and equitably implement DMTs for AD. Strengthening the infrastructure to support care partners is not only foundational to system readiness for DMTs but will also enhance quality of life for all people living with dementia, including those who are not eligible for treatment, and for their care partners.

Mapping and Prioritizing Barriers to Readiness for DMTs in Canada

After an open discussion on the barriers to system readiness for DMTs in Canada, roundtable participants were asked to prioritize barriers that were in urgent need of actionable solutions at different levels of impact. Key areas for prioritization of solutions are summarized in **Table 1**. At the system level, key barriers for prioritization of solutions included inertia and apathy of senior leadership, lack of a coordinated and collaborative system for diagnosis and care, and access to diagnostic testing. At the physician level, lack of appropriate funding was deemed the most urgent barrier, as lack of funding results in lack of training, time, and resources for physicians. At the patient and care partner level, lack of public knowledge and awareness of AD, dementia, and DMTs, as well as integration and support of care partners early in the AD journey were deemed the most urgent barriers to address.

Table 1: Prioritized barriers to DMT system readiness for urgent action

Key theme	Barriers by impact level		
	System	Healthcare provider	Patient/Care partners
Data acquisition and standardized targets	• Lack of data to support benchmarks and accountability		
Awareness and attitudes	• Inertia and apathy of senior policymakers ("why bother" attitude)	• 'Why bother?' attitude • Lack of knowledge on diagnostic testing • Do not want responsibility of taking away driver's license	• 'Why bother?' attitude • Lack of knowledge/awareness of early signs and symptoms • Mistrust in healthcare system • Lack of understanding on diagnosis • Denial/fear of symptoms or diagnosis • Stigma • Fear of losing driver's license
HCP access, capacity, and training	• Personnel shortages (e.g. nurses, specialists) and workload capacity • Appropriate funding for multidisciplinary teams	• Lack of time to do proper assessments • Lack of training and funding for training • Adequate remuneration/compensation for providers • Lack of resources (nurses/staff)	
System fragmentation and complex navigation	• Lack of clear dementia care pathways/navigation through pathway • Lack of EMR interoperability	• Poor collaboration between primary, specialist, and community care/fragmented communication	• Dismay/overwhelm by system
Access to diagnostics and biomarker testing	• Lack of access for diagnostic tests (e.g. PET, lumbar puncture/CSF, MRI)	• Lack of diagnostic testing complete at first specialist appointment	
Care partner support and services	• Lack of support/recognition for family/care partner • Lack of in-home support and long waitlists for long-term care		• Lacking an advocate/support system/care partner • Lack of support/recognition for family/care partner • Care partner time, capacity, ability • Cost (missed work) and transportation
Prioritization for solutions	• Inertia and apathy of senior leadership • Lack of a coordinated collaborative system • Access to diagnostics	• Lack of appropriate funding creating gaps in training and strained resources	• Lack of patient knowledge and awareness • Integration of care partner and support for care partners at onset

Solutions to advance system readiness for DMTs

Participants were divided into breakout groups to develop and present one actionable solution to advance system readiness for DMTs in Canada. Proposed solutions are discussed below and summarized in **Table 2**.

Solutions: Public Education, Engagement & Primary Care Enablement

Roundtable participants emphasized that limited awareness and outdated attitudes toward dementia remain major barriers to system readiness for DMTs. To address these barriers, a coordinated, multipronged education strategy should be initiated with the following steps:

1 Launch a National Public Awareness Campaign

A nationwide campaign should:

- **Increase public understanding** of early dementia symptoms, when to seek care, and how it can be managed.
- **Counter misconceptions** that dementia is an inevitable part of aging and promote the benefits of early detection and treatment.
- **Be led by the Public Health Agency of Canada (PHAC)** in partnership with the Alzheimer Society of Canada and a coalition of clinical experts to ensure messaging is evidence-based, patient-centred, and clinically accurate.
- **Engage local communities** to tailor messaging for cultural and linguistic diversity, ensuring the campaign resonates with equity-deserving populations across Canada.
- **Include individuals with lived experience and civil-society thought leaders** to strengthen authenticity, cultural relevance, and public trust.

Although the Government of Canada has supported some awareness initiatives as part of the national dementia strategy, current efforts lack the breadth and reach needed to prepare Canadians for the arrival of DMTs. This campaign should achieve visibility and reach comparable to the FAST stroke campaign, which successfully educated the public on early stroke recognition and the urgency of treatment.[64]

2 Strengthen Primary Care Knowledge and Confidence

- **Integrate updated diagnostic guidance** into continuing medical education (CME) programs, including use of cognitive screening tools, biomarkers, and referral protocols.
- **Provide clear clinical pathways** outlining when and how to refer patients for specialist assessment and diagnostic testing.
- **Include practical training** on DMT eligibility, treatment monitoring, and communication skills to support sensitive discussions about diagnosis and care planning.
- **Deliver CME programs** through accessible formats (accredited online courses, interactive webinars, and in-person workshops) to ensure equitable participation across urban, rural, and remote regions.

3 Foster Multidisciplinary Collaboration and Knowledge Sharing

- **Establish regular case-based learning sessions, interprofessional workshops, and national knowledge-exchange networks** to promote collaboration among neurologists, geriatricians, geriatric psychiatrists, primary-care providers, nurses, and allied health professionals.
- **Encourage cross-discipline mentorship and best-practice dissemination** to ensure consistent, informed approaches to dementia diagnosis and care.

Solutions: Health System Policy & Equity

Roundtable participants emphasized that a coordinated, data-driven, and equity-focused policy framework is essential to ensure that Canada's health systems are ready to implement DMTs for AD. Achieving this will require a clearly defined dementia pathway, dedicated coordination structures, and the use of performance measurement systems that drive continuous quality improvement. This is similar to other models in Canada that have proven successful in disease areas such as cancer, kidney disease, and mental health and addictions.[51,65,66] The Alzheimer Society of Canada, in partnership with PHAC and provincial health ministries, could lead development of this framework as both an implementation blueprint and an advocacy tool to promote system-wide planning and sustainable funding. Key steps are to:

1 Develop a National Dementia Pathway

- **Provide clear guidance for provinces and territories**, with flexibility to adapt to regional contexts.
- **Address equity for priority populations**, including those in rural and remote communities, Indigenous Peoples, and individuals facing linguistic or cultural barriers.
- **Leverage virtual care and province-wide service models** to minimize the need for travel to tertiary centres.

2 Create a Dementia Care System Performance Framework

- **Establish a central point of accountability and oversight** for dementia care across Canada.
- **Develop a common set of performance indicators**, including metrics for access, quality, timeliness, and equity.
- **Enable public reporting** to promote transparency, drive accountability, and support evidence-informed decision-making.

3 Establish Dedicated Provincial Dementia Branches

- **Serve as a central liaison** between ministries of health, clinical networks, and community organizations.
- **Oversee integration of DMTs** into care pathways and monitor uptake and outcomes.
- **Ensure accountability and consistent reporting**, using shared data standards and quality metrics.

4 Implement a Dementia-Specific Funding Model

- **Consolidate funding across the continuum of care**, including diagnostics, imaging, biomarker testing, treatment, and follow-up.
- **Mitigate siloed decision-making and fragmented funding** that impede timely access to new therapies.
- **Enable proactive resource planning and equitable distribution** of services across regions

5 Embed Equity and Cultural Safety as Core Principles

- **Embed equity goals and performance indicators** into all national and provincial dementia strategies.
- **Partner with Indigenous, rural, and culturally diverse communities** to co-design programs that reflect local realities and values.

Solutions: Diagnostic access

Biomarker testing for AD is an essential part of diagnosis and determining eligibility for DMTs. As there are currently no standardized diagnostic pathways for AD in Canada, most patients with suspected AD must wait until their first specialist consultation before they are offered biomarker testing. Patients must then wait for access to the tests themselves and for a follow-up appointment with the specialist to review results. These compounded delays—from initial referral to treatment planning—are significant, with many patients pushing past the window of opportunity to receive DMTs.

Some roundtable participants proposed a model where biomarker ascertainment occurs prior to specialist review (biomarker-first model). This model would allow people with suspected AD to have their biomarker test results available at the initial specialist appointment which would help expedite diagnosis and treatment planning. The feasibility of this model in the Canadian healthcare system was demonstrated in the bioMIND study conducted in London, Ontario.[67] In this study, information from primary care providers was used to screen patients for other DMT eligibility factors prior to biomarker test ordering, allowing potentially eligible patients to undergo testing in advance. This process resulted in expedited time from referral to diagnosis of 250 days compared to 712 days for the control cohort (a difference of 438 days or ~1.2 years). Emerging blood-based biomarkers may also facilitate the uptake and success of this model.

A biomarker-first model has successfully been used in other disease areas in Canada. For example, provincial health authorities like Cancer Care Ontario (a part of Ontario Health) implemented the lung diagnostic assessment program (LDAP)[68] and, more recently, the Comprehensive Cancer Biomarker Testing Program[69] to expedite diagnosis for patients with suspected lung cancer and provide reimbursement for biomarker testing. Like AD, lung cancer also heavily relies on biomarker information to inform treatment. In this model, patients are referred by their primary care provider to a regional LDAP, where their information is centrally assessed and diagnostic tests are coordinated by a nurse navigator. Upon confirmation of stage 4 lung cancer, reflex biomarker testing can be performed by the pathologist on patient samples, reducing the time to obtain results and, consequently, the time to treatment initiation.[70] To replicate these successes in dementia care, a set of actionable steps is needed:

1 Establish Standardized Diagnostic Pathways

- **Develop national and provincial guidelines** outlining when and how to use biomarker testing.
- **Integrate primary and specialty care in diagnostic pathways**, enabling pre-screening and early test ordering.

2 Secure Equitable Access to Biomarker Testing

- **Introduce public reimbursement** for validated biomarker tests (e.g., CSF, PET, and emerging blood-based biomarkers).
- **Ensure equitable access across regions**, including rural and remote areas.

3 Fund Coordination Roles

- **Support nurse navigators/case coordinators** to manage referrals, testing logistics, and follow-up.

4 Create Oversight and Performance Benchmarks

- **Assign accountability** to dedicated provincial dementia branches
- **Set and monitor benchmarks for timeliness**, from referral to diagnosis and treatment initiation.
- **Report publicly on system performance** to drive improvement.

Table 2. Actionable solutions for enhancing DMT readiness in Canada

Theme	Actionable solutions	Champions
Public Education, Engagement & Primary Care Enablement	• Develop public national dementia awareness/education campaign with broad reach and cultural relevance. • Train primary care teams on early diagnosis and DMT eligibility. • Provide accredited online/onsite education and multidisciplinary knowledge exchange.	**Lead:** • Public Health Agency of Canada **Collaborators:** • Alzheimer Society of Canada; clinical experts; local community groups; professional associations
Health System Policy & Equity	• Develop a flexible national dementia pathway for all provinces and priority populations to customize and implement. • Advocate federally and provincially for funding and implementation. • Establish dedicated dementia branches within provincial health authorities. • Establish a system performance framework to ensure accountability. • Use disease-specific budgets, following cancer care models.	**Lead:** • Alzheimer Society of Canada **Collaborators:** • Public Health Agency of Canada; provincial health ministries; provincial dementia units
Diagnostic Access	• Implement a biomarker-first model for faster diagnosis and treatment planning. • Create centralized coordination roles to screen patients with suspected AD before testing. • Ensure public reimbursement for biomarker tests.	**Lead:** • Provincial health authorities **Collaborators:** • Public Health Agency of Canada; Alzheimer Society of Canada; primary care networks; specialist clinics

Conclusion

Canada stands at a pivotal moment in dementia care. Disease-modifying therapies (DMTs) are on the horizon in Canada, and with them comes an opportunity to shift from a reactive to a proactive system. By acting now, before DMTs are introduced, Canada can build the diagnostic and treatment infrastructure that will not only enable timely access to these new therapies but also improve care for all people living with dementia.

The nine calls to action in this report provide guidance on where system enhancements can be prioritized for the seamless integration of DMTs. History shows that seemingly overwhelming innovations, such as the rollout of renal dialysis, can be successfully organized when governments, clinicians, and communities work together. With the same determination, Canada can create a dementia care system that is prepared for DMTs and that delivers lasting benefits to patients, care partners, and society as a whole.

Calls to Action

Roundtable discussions were summarized into nine priorities to enhance healthcare system readiness for DMTs:

1. **Launch a National Public Awareness Campaign**
   Increase understanding of early dementia symptoms, reduce stigma, and encourage timely help-seeking.

2. **Establish Measurable National Benchmarks and Robust Data-Monitoring Systems**
   Set targets for time to diagnosis and treatment initiation and implement data-monitoring systems to track and publicly report progress.

3. **Create Provincial Dementia Care Bodies**
   Establish branches within each province that oversee funding, standardized diagnostic pathways, and planning for dementia care.

4. **Expand Training for Primary-Care and Allied Health Professionals**
   Provide education on cognitive screening, biomarker use, referral pathways, and effective communication with patients.

5. **Increase Multidisciplinary Collaboration and Knowledge Exchange**
   Promote workshops and knowledge-exchange to share best practices across neurology, geriatrics, primary care, and allied health.

6. **Integrate Biomarker Diagnostics into Clinical Pathways**
   Publicly reimburse biomarker testing and build coordinated diagnostic workflows to accelerate eligibility evaluation for DMTs.

7. **Increase MRI and Amyloid-PET Imaging Capacity**
   Expand access to imaging, neuroradiology services, and training to meet diagnostic and monitoring needs for patients with DMTs.

8. **Support and Fund Care Partner Services**
   Provide respite care, navigation assistance, and care partner support to reduce burden and enable equitable access to treatment.

9. **Strengthen System Navigation**
   Introduce standardized referral pathways and increase funding for navigator roles to guide patients and families through the care pathway.

Limitations

This report reflects the perspectives and recommendations of a relatively small, convenience sample of dementia experts and individuals with lived experience. While the discussions incorporated a broad variety of viewpoints, they are not exhaustive, and other important perspectives may not have been captured. The primary focus of the roundtable and this report was on system preparedness for DMTs for AD. Although many of the proposed solutions would also benefit the broader population of people living with dementia, additional strategies are needed to address other critical aspects of dementia care, including late-stage management, comorbidities, and support for diverse populations not fully represented in this analysis.

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Appendix A:
Roundtable Participants and Agenda

Table 1. Participants in advisory group

Name	Role/Institution	Location
Clinicians/Researchers		
Dr. Sarah Mitchell (SM)	Cognitive Neurologist, Sunnybrook	Toronto, ON
Dr. Linda Lee (LL)	Family Physician (Specialty in Elder Care), MINT	Kitchener, ON
Dr. Alexandre Henri-Bhargava (AHB)	Neil & Susan Manning Cognitive Health Institute	Victoria, BC
Dr. Sandra Black (survey participation)	Neurologist, Senior Scientist Sunnybrook Health Science Centre	Toronto, ON
Dr. Morris Freedman (survey participation)	Neurologist, Baycrest Health Sciences	Toronto, ON
Dr. Jaspreet Bhangu (JB)	Geriatrician, St. Joseph's Health Care London	London, ON
Administrators		
Elizabeth Lewis (EL)	International Federation on Aging (IFA)	Toronto, ON
Katrina Bouzanis (KB)	Director, Policy and Advocacy, IFA	Toronto, ON
Dr. Kelly Kay (KK)	Provincial Geriatrics Leadership Ontario	Toronto, ON
Lisa Levin (LLe)	AdvantAge Ontario	Toronto, ON
Deb Galet (unable to attend)	Ontario Dementia Care Alliance, CEO, Baycrest Hospital	Toronto, ON
People with lived experience & Care partners		
Ngozi Iroanyah (NI)	Care partner and Director, Health Equity & Access, ASO	Toronto, ON
Lee Laforest (LLa)	Care partner	Barrie, ON
Claire Webster (CW)	Care partner and Ministerial Advisory Board of Dementia, Dementia Education Program at McGill University	Montreal, QC

Table 2. Roundtable meeting observers

Name	Role/Institution	Location
Alzheimer Society of Ontario		
Adam Morrison	Senior Director, Public Policy & Partnerships	Toronto, ON
Julie Datta	Manager, Research & Evaluation	Toronto, ON
Shawn Paron	COO at ASO	Toronto, ON
Cathy Barrick	CEO at ASO	Toronto, ON
Edelman Canada		
Scott Evans (SE)	Roundtable Facilitator | GM (Toronto) & National Lead, People & Operations	Toronto, ON
Lucy Hopkins	Account Director, Health	Toronto, ON
Leslie Sim	Account Manager, Health	Toronto, ON
IMPACT Medicom		
Sarah Doucette	Senior Medical Writer	Toronto, ON
Observers		
Kristina Gentes	Senior Lead, Patient Access & Stakeholder Engagement, Eisai	Mississauga, ON
Adam Haynes	Associate Director, Market Access & Government Affairs, Eisai	Mississauga, ON
Ethan Pigott	Director, Communications & External Affairs, Lilly	Toronto, ON
Mathilde Merlet	GM, Lilly	Toronto, ON
Karl Charles-Pierre	Head of Immunology, Lilly	Toronto, ON
Kristin Madsen	Neurology Commercial Lead, Lilly	Toronto, ON
Luc Boulay	Neurology Medical Lead, Lilly	Toronto, ON
Emi Yasukawa	Sr Director, International Communications (Neurology & AD), Lilly	Toronto, ON
Rylend Mulder	Medical Advisor, Novo Nordisk	Mississauga, ON
Kaushik Sripada	National Healthcare Systems Partner, Pipeline, Roche	Mississauga, ON
Michelle Santos	Medical Strategy Leader, Neuroscience Pipeline, Roche	Mississauga, ON

Table 3. Roundtable meeting agenda

Time	Topic	Speaker/ Moderator
10 min	**Welcome and Introductions** • Welcome participants • Participants to introduce themselves • Review objectives and agenda • Review anticipated meeting outcomes/outputs • Refer to pre-survey and how it will guide our discussion today	Scott Evans, Edelman Cathy Barrick, ASO
20 mins	**International Experiences and Understanding the Need in Canada** • Identifying the right patient at the right time – the importance of the diagnostic timeline • Current status of DMTs in Canada and around the world – a discussion around risk/benefit (i.e. leverage examples in oncology, etc.)	Scott Evans, Edelman
20 mins	**Barriers to Readiness** • Discuss key themes and clarify details as required from pre-session survey • Addressing the challenges identified in the pre-session survey	Scott Evans, Edelman
30 mins	**Actionable Solutions for Implementation and Equity** • Discuss key themes and clarify details as required from pre-session survey • Opportunities to drive advocacy for access to DMTs at a provincial and federal level • Opportunities to improve the response of the Canadian health system to new therapies	Scott Evans, Edelman
5 min	**Next Steps and Closing Remarks** • Review next steps (including follow-up regarding interest in future updates and collaborations)	Cathy Barrick, ASO
5 min	**Close** • Thank you • Evaluation survey to follow via email	Scott Evans, Edelman

Appendix B:
Select pre-meeting survey results

1. SKIP EXCEPT FOR HCP/Health System/Policy Leader/Advocate/Non-Profit Partners: What are current barriers that might inhibit receiving a diagnosis of Alzheimer's disease in Canada?

Answer Choices	Responses	
Low recognition of symptoms	35.71%	8
Patient isolation (no close family, care partner, etc.) to identify disease markers	0.00%	3
Inadequate physician education	7.14%	4
Lack of access to an HCP	21.43%	7
Limited capacity of medical imaging	7.14%	4
Other (please specify)	28.57%	1
	Answered	**14**
	Skipped	**1**

2. SKIP EXCEPT FOR RESPONDENTS WITH LIVED EXPERIENCE/CARE PARTNERS: What are current barriers that might inhibit receiving a diagnosis of Alzheimer's disease in Canada?

Answer Choices	Responses	
I do not have a family doctor	42.86%	3
My family doctor is not comfortable testing or diagnosing me	28.57%	2
It takes too long to see a specialist for a diagnosis	100.00%	7
Other (please specify)	28.57%	2
	Answered	**7**
	Skipped	**8**

System Readiness:

3. **SKIP EXCEPT FOR HCPs: Do you believe the current guidance for diagnostic imaging and bio-marker based testing to diagnose Alzheimer's disease is clear and well understood by clinicians?**

Answer Choices	Responses	
Yes	0.00%	0
Somewhat	20.00%	2
No	70.00%	7
I don't know/not sure	0.00%	0
Other (please specify)	10.00%	1
	Answered	**10**
	Skipped	**5**