

JERRY PERONE / ALZHEIMER'S ADVOCACY

The Story of Hawai'i's Continuum of Hope

PART 2 / AN ILLUSTRATED STORY



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Fictional narrative and policy vision

Cover photograph: National Park Service, public domain; retained from source.

PART II. The Story of Hawai‘i’s Continuum of Hope

The following section is written as a fictional narrative. The characters are fictional, but the policy architecture is real. The purpose is to help readers feel the continuum, not merely understand it. In the story, the system works as it should: earlier detection opens a door, trained providers know what to do, navigators walk with families, technology supports dignity, and data improves the next response.

Music direction for presentation: use a gentle, licensed or royalty-cleared instrumental arrangement of “Aloha ‘Oe.” Begin softly under the cover page, keep the melody low enough that narration remains clear, let it lift under the canoe chapter, and fade into quiet before the final blessing.



Photo: sunrise above Haleakalā - a visual cue for hope, time, and a new horizon. Source: National Park Service, public domain.

Prologue: The Morning the Ocean Looked Different



Photo: Kaula coastline - the story opens where beauty and distance both shape care. Source: USGS, public domain.

The morning began on Kaua'i with rain over Hanalei and a thin silver road of sunlight opening across the bay. Leilani Akana stood in her mother's kitchen and watched Tūtū Rose hold a pill bottle in one hand and the rice-cooker lid in the other. The rice had finished. The tea had gone cold. The bottle was open.

"Tūtū," Leilani asked gently, "did you already take these?"

Rose looked at the bottle, then at her daughter, then toward the window where the mountains wore a shawl of cloud. "I thought I knew," she said. "Then it slipped away."

Leilani felt the old fear rise in her chest. She knew the fear because every family learns its shape: the midnight internet search, the months of waiting, the whispered question of whether this is normal aging or something more serious, the private shame of not knowing what to do next.

But this morning was different. The islands had begun to build a path where before there had been a cliff. There was a number to call. There was a trained person who would answer. There was a system meant to meet a family before the fall. Leilani breathed in, held the bottle steady, and said, "We are not going to carry this alone."

For the first time, the word hope did not feel like denial. It felt like a door.

Chapter 1: The Old System Had a Sound

The old system had a sound. It was the ring of a phone that no one answered. It was the click of a referral sent somewhere into silence. It was the sigh of a caregiver who had been told to "come

back when things get worse.” It was the emergency-room monitor beeping after a preventable crisis had already become expensive, frightening, and traumatic.

Families did not call it fragmentation. They called it Tuesday. A missed bill. A stove left on. A father found walking at dusk. A mother repeating the same question and apologizing every time. A spouse sleeping in a chair because the person they loved wandered at night. In the old system, families learned to become schedulers, nurses, safety officers, insurance clerks, and detectives.

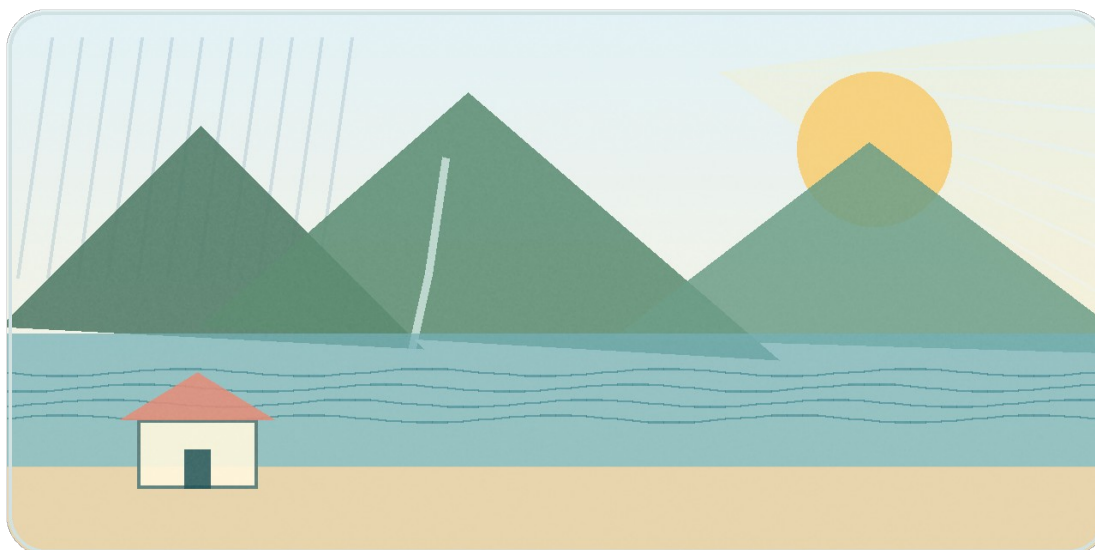
Leilani remembered her neighbor Kimo, who had flown his father to Honolulu three times and still came home with no care plan that the family could use. She remembered Auntie Pua, who waited so long for a specialist that the first real intervention happened after a fall. She remembered the way people lowered their voices when they said dementia, as if whispering could make it less real.

National policy had begun to move years earlier. The National Alzheimer’s Project Act helped turn scattered federal effort toward a coordinated national plan. The BOLD Infrastructure for Alzheimer’s Act helped bring dementia into public health: early detection, risk reduction, caregiver support, avoidable hospitalization, data, and community capacity. But national movement still had to become local care.

Hawai’i understood the challenge with unusual clarity. The same ocean that makes the islands beautiful can make care feel far away. O’ahu may have more specialists. Neighbor islands may have longer waits, fewer clinics, fewer transportation options, and more families trying to solve a progressive disease with love alone.

Love is powerful. But love without a system can become exhaustion. Hawai’i’s question became simple and enormous: what would it take to turn love into a continuum?

Chapter 2: Hawai’i Chooses a Different Path



Original illustration: a small home facing weather - the old system left families exposed.

Between 2021 and 2026, the ground shifted beneath Alzheimer’s care. New blood-based diagnostic aids made earlier, less invasive evaluation more realistic for people who already had symptoms. New treatments showed that selected people with early Alzheimer’s disease might have options to

slow decline, even though the treatments were not cures and required careful monitoring. CMS launched GUIDE, built around dementia care navigation and caregiver support. Congress considered ASAP and AADAPT, bills that spoke to two missing links: access to modern testing and access to trained providers.

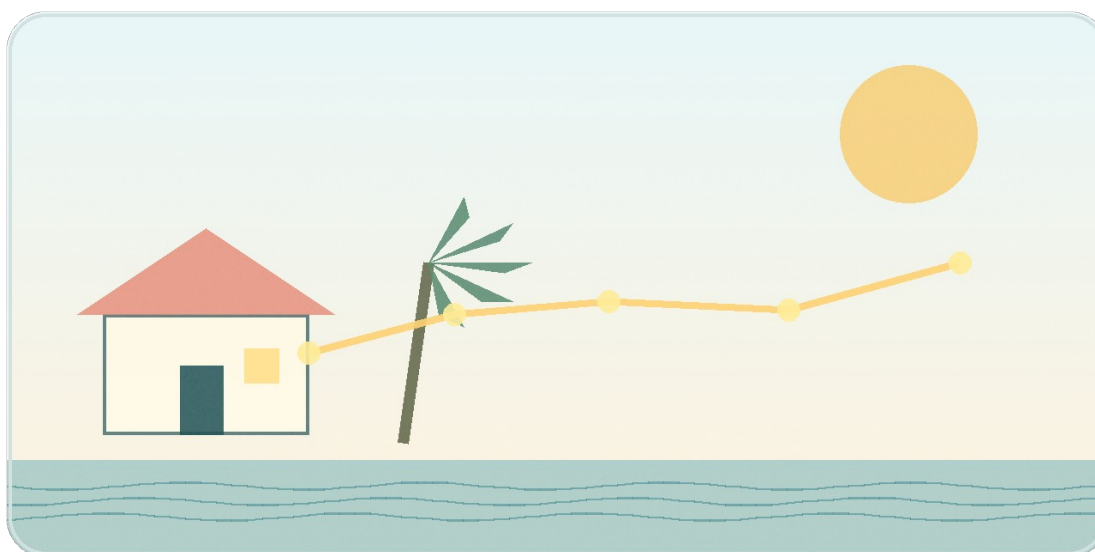
Then another kind of evidence arrived. The U.S. POINTER Study showed that brain-health action did not have to wait for a miracle drug. In older adults at risk of cognitive decline, multidomain lifestyle programs improved cognition, and the more structured program - with support, goals, and accountability - helped more. To Leilani, it sounded almost too ordinary: walking, food, thinking, friendship, blood pressure, sleep, follow-through. But ordinary things, organized well, could become a second paddle in the canoe.

For a while, the pieces looked like separate lights scattered across dark water. One light was screening. Another was training. Another was Project ECHO. Another was GUIDE. Another was HANAI. Each one helped, but no single light showed the whole channel.

Then the idea changed. Hawai'i would not choose one tool and call it enough. The answer would be lōkahi - unity. Screening had to lead to evaluation. Evaluation had to lead to diagnosis. Diagnosis had to lead to navigation. Navigation had to lead to a care plan. A care plan had to lead to services, caregiver support, technology where appropriate, and follow-up. Follow-up had to produce data. Data had to improve the next response.

That was the promise behind HANAI: not merely a program name, but a statewide circle of care. Hānai carries the sense of nurturing, feeding, caring for, and receiving someone into family. In the story Hawai'i began to tell, a person with memory loss was not passed from office to office. The person was received.

Chapter 3: The Call That Changed the Room



Original illustration: the first bridge is a call that reaches a real pathway.

Leilani called after breakfast. She expected a menu, a recording, a message saying someone would get back to her later. Instead, a calm voice answered.

“HANAI Memory Network. This is Malia.”

Leilani had rehearsed what to say, but the words scattered. “It’s my mother. She is forgetting things. I do not know if I am overreacting. I do not know where to begin.”

Malia did not rush her. She asked what Leilani had noticed: medication confusion, repeated questions, missed bills, falls, driving concerns, sleep disruption, wandering risk, caregiver strain. She asked what Rose could still do, what had changed, who was helping, and what frightened Leilani most.

For the first time, the questions themselves felt like care. They did not make Rose smaller. They made the problem more visible. Malia asked whether Leilani could gather the medication bottles, write down three recent examples of change, and identify a family member who could join the first care discussion by video.

Then Malia said the sentence that changed the room: “You did the right thing. We are going to walk with you.”

It was not a cure. It was not a promise that the road would be easy. But it was the first sign that the family was inside a system designed to respond before the crisis. Leilani looked at her mother, who was listening from the table, and Rose’s shoulders lowered as if a weight had shifted from one body into many hands.

In the continuum, the first intervention is not a test. It is being answered.

Chapter 4: The Appointment That Almost Failed

The first appointment almost failed. A storm moved across the island, the road near Hanalei slowed, and Rose woke up certain that she did not want to go. “I am not sick,” she said. “I just forgot one thing.”

Leilani felt panic rise. The old system would have turned the missed appointment into a delay measured in months. But Malia had already prepared for this. She called before they left the house. She spoke to Rose, not around her. She explained that the appointment was not a judgment. It was a way to understand what was changing and what could still be protected.

The clinic shifted the first visit to telehealth, with an in-person follow-up scheduled if the clinical team needed it. Rose’s son in Nevada joined by video. Dr. Keoni, a primary care physician on Kaua’i who had completed dementia training and joined Project ECHO sessions with specialists on O’ahu, appeared on the screen with a calm face and a yellow legal pad.

He did not pretend that one test could explain a life. He began with history, function, memory questions, medication review, safety, mood, sleep, and family concerns. He asked Rose about her garden. He asked Leilani what had changed. He asked the son in Nevada what he noticed during calls. Slowly, the picture sharpened.

By the end of the visit, the family did not have an answer yet. But they had not lost the appointment. They had not been sent back to the beginning. The continuum had bent around real life instead of breaking against it.

Chapter 5: A Blood Draw, A Question, and a Door

At the clinic the following week, Rose rolled up her sleeve. “All this from my blood?” she asked.

Before the needle touched Rose’s arm, the room grew quiet for a different reason. Leilani had one more question, the kind families ask in a whisper because the answer can change everything.

“What if insurance does not cover it?”

Rose surprised them both by asking a different question. “If knowing early gives me a chance to do something, then why would I not want to know?” Malia had heard versions of that sentence before. It matched what the national survey had found: most Americans wanted earlier knowledge, and many would accept real treatment risk if a medication might slow the disease. But Malia also knew the duty that came with that courage. Wanting to know did not remove the system’s responsibility to explain, protect, and guide.

Malia did not dismiss the question. She explained that some Alzheimer’s blood biomarker tests could cost hundreds of dollars out of pocket and that a working planning estimate was about \$1,000, possibly more or less depending on the test and laboratory. Leilani looked at her mother and thought of groceries, rent, airfare, and the quiet arithmetic caregivers do in their heads. The blood draw was small. The decision around it was not.

That was when HANA I mattered again. The navigator checked coverage, asked about financial hardship, explained that no test should be ordered without a plan for what came next, and made sure the family understood the cost before consenting. The drama was not only medical. It was moral: would clarity belong only to families who could afford it, or would Hawai’i build a front door wide enough for everyone?

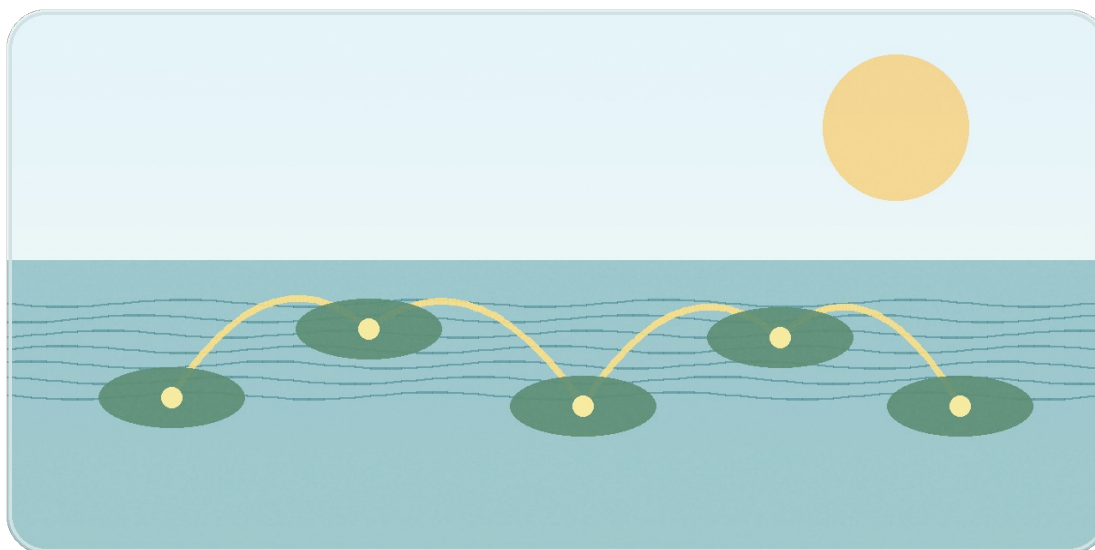
“Not all,” Dr. Keoni said. “This test is one piece of the picture. We use it with your symptoms, exam, memory testing, and other information. It can help us decide what to do next. It is not a label thrown at you from across the room.”

Leilani watched the vial fill. It seemed too simple for something so frightening. But that was the point. For decades, families waited until symptoms were obvious, crisis was near, and options had narrowed. Now the system was learning to look earlier, listen earlier, and respond earlier.

Two weeks later, the result did not hand them a miracle. It handed them clarity. Rose needed further evaluation. There were questions about staging, treatment eligibility, safety, and caregiver support. In the old system, clarity might have been where a family was left alone with fear. In the continuum, clarity was where navigation began.

Leilani expected to feel only dread. Instead, she felt something more complicated and more useful: grief with instructions. Fear with a phone number. Uncertainty with a next appointment already scheduled.

Chapter 6: The Result That Needed a Team



Original illustration: islands connected by a shared pathway of knowledge.

A result is not a plan. Dr. Keoni knew that. Malia knew it too. So the next step was not to send Rose away with a printout. The next step was to assemble the team.

Dr. Keoni reviewed the medications and found two that might worsen confusion. Malia completed a caregiver assessment with Leilani and discovered that she had not slept through the night in months. The clinic nurse asked about falls and hydration. The social worker asked about legal papers, transportation, food, respite, and whether the family had someone who could help if Rose wandered.

The result created questions. The continuum created a place for those questions to go. That was the difference. The family was not being pushed deeper into a maze. The maze was beginning to unfold into a map.

One question remained: could Rose be a candidate for disease-modifying therapy if further evaluation confirmed the right stage and pathology? Dr. Keoni refused to rush the answer. He explained the possible benefits, the risks, the monitoring burden, and the fact that not every patient is eligible or should choose treatment. Hope, he said, must tell the truth.

The question opened two possible futures. In the first, if Rose qualified and chose treatment, the earliest phase would still be anchored at a clinic: an island memory clinic or infusion partner where staff could monitor symptoms, coordinate MRIs, and respond if anything went wrong. That path felt heavy, but it also felt safe. Rose imagined the clinic as a canoe landing: not the whole voyage, but a place where trained hands helped her step in.

In the second future, if Rose completed the required initial treatment phase and remained eligible, a maintenance option might eventually move some of the burden home. A trained patient or caregiver could use a weekly subcutaneous autoinjector, while the clinical team continued to watch for danger, reassess ability, track missed doses, and keep the emergency plan alive. Leilani saw the

promise immediately: fewer trips, less waiting, more life around care instead of care swallowing life.

Dr. Keoni did not let hope run ahead of safety. “Home is not the same as alone,” he said. “If this ever becomes your path, the clinic still walks with you.”

Chapter 7: Knowledge Crosses the Ocean

On Thursday afternoon, Dr. Keoni joined a Project ECHO session. On the screen were clinicians from O’ahu, Maui, Kaua’i, Hawai’i Island, and Moloka’i. There was a geriatrician, a neurologist, a pharmacist, a social worker, a care navigator, and primary care providers who had brought de-identified cases. No one pretended to know everything. That was the strength of it.

“Move knowledge, not patients,” the ECHO director said. “That is how we serve Hawai’i.”

Dr. Keoni presented Rose’s case without her name. The team discussed medication review, caregiver support, eligibility for further evaluation, safety planning, and whether disease-modifying treatment might eventually be appropriate if clinical criteria and biomarker evidence supported it. They discussed risks, not just hope. They discussed burden, not just biology.

A pharmacist flagged a medication issue. A social worker suggested a caregiver support group that met virtually and included neighbor-island families. A neurologist recommended the threshold for specialty referral. A Maui physician described a similar case where the family had delayed legal planning too long. A DCS from Hawai’i Island shared a safety checklist that had prevented a wandering crisis.

By the end of the session, Dr. Keoni had a clearer plan. Rose did not have to fly to Honolulu for every answer. The expertise had come to Kaua’i.

Chapter 8: Mālama Becomes a Plan



Original illustration: the care plan belongs on the kitchen table, where families actually live.

Malia came to the Akana home with a folder, a tablet, and the patience of someone who understood fear. She sat at the kitchen table where Rose had taught grandchildren to roll laulau and where Leilani now kept a notebook full of appointments.

The care plan was not complicated. That was its beauty. It listed the diagnosis status, current questions, medications to review, safety steps, driving discussion, caregiver supports, respite options, legal and financial planning reminders, emergency contacts, and follow-up dates. It included a caregiver assessment for Leilani. For the first time, someone measured her exhaustion as if it mattered.

The plan also included a brain-health lane inspired by U.S. POINTER: gentle walking that Rose could tolerate, food changes that respected local tastes, a weekly card group so cognitive challenge did not feel like homework, and health-monitoring goals that Dr. Keoni could follow. It was not presented as blame. No one told Rose she had caused her illness. The message was kinder and stronger: there are things we can still do together.

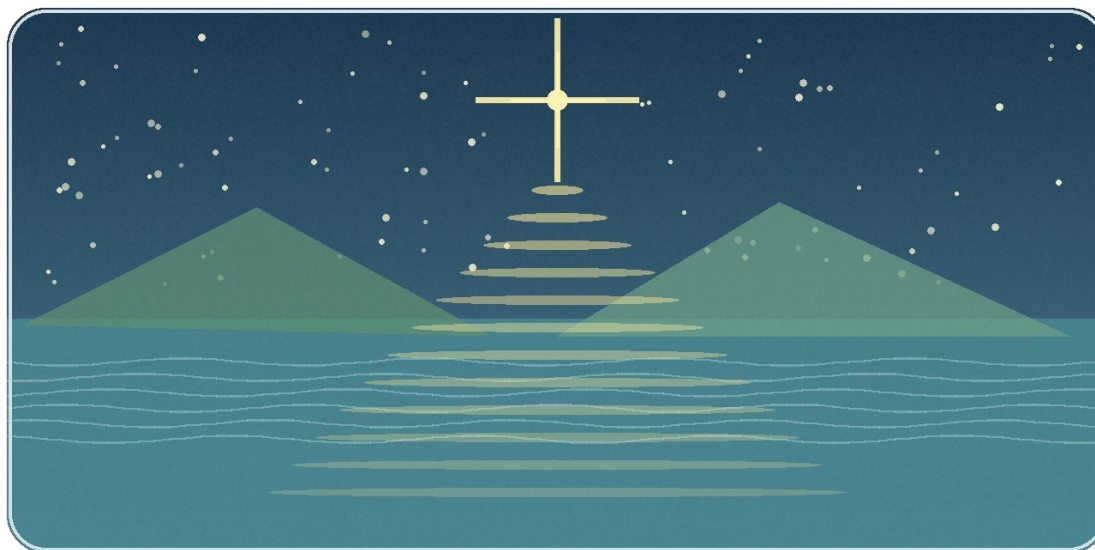
"This is not just for your mother," Malia said. "This is for you too."

Rose traced one finger across the printed page. "So this is what we do next?"

"This is what we do next," Malia said. "And when it stops working, we change it. A care plan is alive."

Leilani looked down at the plan and realized it was not merely paperwork. It was a promise written in operational language. Mālama had become a workflow.

Chapter 9: The Night the System Was Tested



Original illustration: a guiding light across dark water - the continuum is tested after hours.

The test came at 1:17 in the morning. Leilani woke to a soft chime from the sensor near the front door. Rose had opened it and stepped onto the porch, confused by a dream that she needed to catch a bus to a job she had retired from twenty years earlier.

The next morning, Leilani almost canceled the walking group. She was tired, angry, and frightened. But Malia reminded her that the prevention lane was allowed to bend. U.S. POINTER had been

structured, but real families needed mercy as well as structure. They shortened the walk, called it a victory, and kept the plan alive.

Leilani found her standing in slippers, looking toward the road. "I am late," Rose said, shivering.

The old system would have made this a private family panic. The new system had prepared for it. The care plan included a nighttime wandering protocol. The door alert had worked. The after-hours line answered. The nurse on call helped Leilani assess whether Rose was injured, feverish, delirious, or simply disoriented. By morning, Malia had scheduled a follow-up to adjust the plan.

No ambulance came. No emergency room lights flashed. No one scolded Rose. The crisis became information, and the information became a better plan.

That night taught Leilani what technology could and could not do. The sensor did not love her mother. The sensor did not understand shame, grief, or the smell of rain on the porch. But it gave Leilani time to love her mother safely. That was enough.

Chapter 10: The Capitol and the Canoe



Photo: Hawaiian canoe in the cove - a real-world image for the policy canoe. Source: National Park Service, public domain.

Years earlier, in hearing rooms at the Hawai'i State Capitol, legislators and advocates had spoken of rising dementia cases, neighbor-island access gaps, caregiver collapse, Medicaid pressure, workforce shortages, and the moral cost of waiting until families broke.

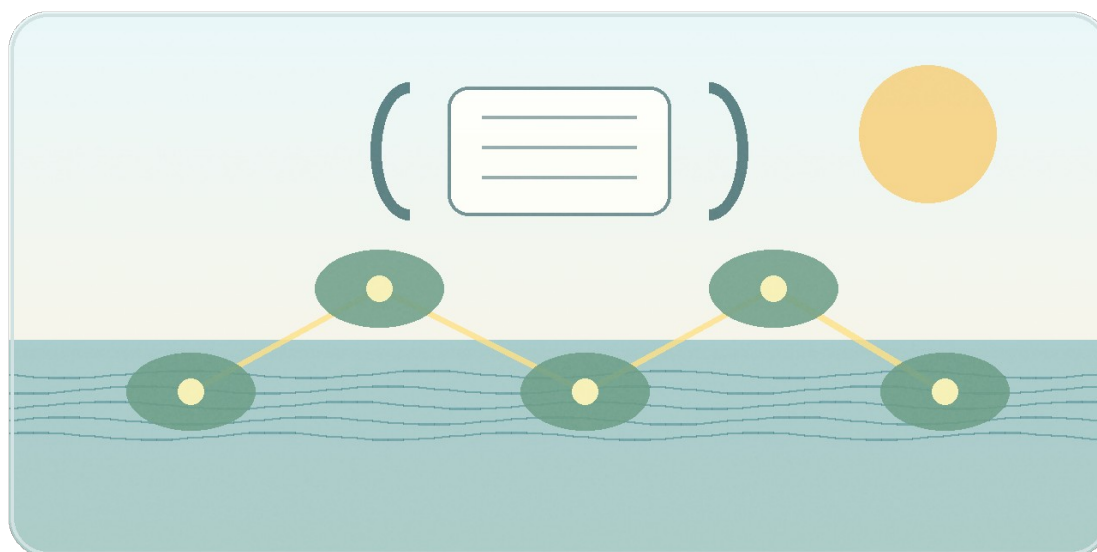
Rep. Gregg Takayama and other House sponsors helped move the HANAI Memory Network concept through the Legislature. Senators including Joy San Buenaventura, Dru Kanuha, and Sharon Moriwaki helped move dementia-related policy through the Senate process. Advocates brought facts. Families brought names. Clinicians brought the memory of patients they could not help soon enough.

The image that stayed with people was a canoe. Federal legislation was one paddle. State funding was another. NIH science was another. FDA review was another. CMS models, Project ECHO, primary care training, community clinics, navigators, caregivers, technology, and data governance were paddles too.

No single paddle could cross the channel. No single law could become care by itself. The canoe moved only when people pulled together, in rhythm, toward the same horizon.

That was the continuum. Not a slogan. A canoe.

Chapter 11: The Dashboard Learns a Name



Original illustration: the dashboard is not cold data; it is a way to learn from families without forgetting them.

In Honolulu, a HANAI dashboard began to show patterns no single family could see. Kaua'i had improved follow-up times. Hawai'i Island still had a backlog. Maui had strong caregiver-education completion but slower referral closure. Moloka'i needed a different outreach strategy because families were not entering through the same front door.

A dashboard can become cold if leaders forget what it measures. Malia did not forget. Every data point had a kitchen table behind it. Every delay was a daughter waiting. Every completed care plan was a family with one less night of panic. Every avoidable emergency visit prevented was a kūpuna sleeping in their own bed.

The dashboard found one problem quickly: families who entered through emergency departments were less likely to receive caregiver assessment within 30 days. HANAI changed the workflow. Discharge summaries began to trigger a navigator alert. DCS staff called within a week. The next month, the gap narrowed.

That was when Leilani understood the word system differently. A system was not a building. It was not a chart. It was a promise that the suffering of one family could teach the system to protect the next family sooner.

Chapter 12: The Pilot That Crossed the Mainland

The first national visitors came quietly. A rural state wanted to know how ECHO helped neighbor-island providers. A large urban state wanted the caregiver assessment and referral-closure dashboard. A tribal health leader asked how the model could respect sovereignty and language. A state Medicaid director wanted to know how small reductions in avoidable crisis use could justify a navigation investment.

Hawai'i did not tell them to copy every island detail. Hawai'i told them the truth: "You do not have our ocean. That means your version can be simpler. But you still have families falling through gaps. Build the continuum."

The replication package grew: a model statute, a dashboard template, a care-plan template, a training curriculum, ECHO case examples, FHIR-ready data definitions, sample contracts, and a first-year launch calendar. States changed the names, the regions, the providers, and the cultural language. But the core remained: screen earlier, train better, diagnose clearly, navigate immediately, support the caregiver, use technology wisely, measure honestly, improve continuously.

The pilot had crossed the channel, then the continent.

Chapter 13: The 2050 Letter



Photo: sunrise from Hōlua Cabin - a warmer horizon for the story's North Star. Source: National Park Service, public domain.

In 2050, Leilani's granddaughter opened a letter Rose had recorded years earlier. By then, brain-health checkups were ordinary. Blood biomarker panels were more precise. Treatments were safer and more personalized. Some people at high risk delayed symptoms long enough to live full

decades they might otherwise have lost. Home technology had become quieter, kinder, and better connected to real care teams.

By then, the U.S. POINTER idea had grown beyond the original study. Brain-health programs were offered through clinics, community centers, churches, senior housing, and health plans. Some were high-touch and structured; others were simpler for families with fewer resources. The lesson had held: prevention works best when it is not a pamphlet, but a pathway.

By then, the old argument between clinic care and home care had become more nuanced. Some treatments were still best delivered in memory clinics, where the team could evaluate, monitor, image, and intervene. Other maintenance therapies had become safe enough for trained home use in selected families, with smart packaging, remote check-ins, symptom prompts, and a human navigator watching for missed doses or warning signs.

In one future scenario, the HANAI Memory Clinic remained the trusted island anchor: the place for diagnosis, staging, treatment initiation, complex monitoring, and family conferences. In the other, home maintenance became the dignity-preserving extension: the medicine came to the family after the family had been trained, the risk plan was clear, and the clinic remained only a call away. The breakthrough was not merely a drug. The breakthrough was choice with safety.

The world was not free of dementia yet. But it was no longer the same world Rose had feared. Fewer families waited until crisis. More caregivers were supported before they collapsed. More primary care clinicians knew what to do. More people joined clinical trials without flying across an ocean. More care plans lived on kitchen tables and in secure electronic records. More dashboards found gaps before those gaps became grief.

The granddaughter heard Rose's voice through the speaker: "If you are hearing this, I hope the world has learned to remember the people who are forgetting. I hope it has learned to walk with them."

Leilani, older now, closed her eyes. She thought of the first blood draw, the first phone call, the night at the door, the canoe in the Capitol story, and the dashboard that had learned from her mother's life. She understood then that the continuum had never been only about disease. It had been about refusing to let families disappear.

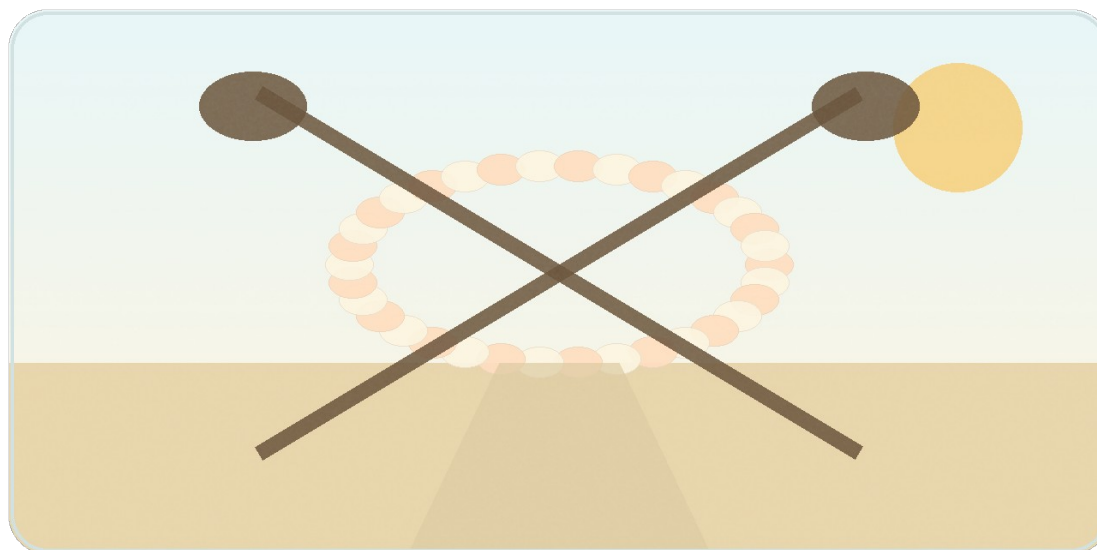
Epilogue: Mana'olana Made Operational

The story ends where the report begins. The path to a world without dementias will require science, legislation, funding, clinical discipline, public health, family support, data, technology, and a change in imagination. We must stop imagining dementia care as a set of disconnected events and start building it as a continuum.

Screen earlier. Train better. Diagnose clearly. Navigate immediately. Support the caregiver. Use technology wisely. Measure honestly. Improve continuously. Keep the 'ohana at the center.

That is Hawai'i's offering: a model that is tender enough to answer a daughter's phone call and disciplined enough to measure whether the answer helped. The world without dementias is not here yet. But the canoe is in the water. The paddles are in our hands. The horizon is visible.

Action Page: What You Can Do Today to Help This Vision Come Into Focus



Original illustration: today's paddle - practical action moves the canoe.

This vision will not come into focus by accident. It needs families, clinicians, policymakers, public agencies, health systems, community partners, researchers, technology builders, and neighbors to pull in the same direction. Here is what readers can do now:

- If you are a family member or caregiver: do not wait for crisis. Write down the changes you see, ask for a cognitive evaluation, request a care plan, and ask who will help you navigate next steps.

Ask also for a brain-health plan. A good plan can include safe physical activity, MIND-style nutrition adjusted to culture and budget, social and cognitive engagement, sleep and hearing checks, blood-pressure and diabetes control, and follow-up goals inspired by U.S. POINTER.

- If you are a clinician: make memory concerns part of routine care, complete dementia-focused training, use evidence-based diagnostic pathways, and connect families to navigation and community supports immediately after concern or diagnosis.
- If you are a policymaker: support ASAP, AADAPT, GUIDE-style navigation, Project ECHO expansion, and sustainable funding for the HANAI Memory Network with island-specific performance measures.

Add U.S. POINTER-style prevention programs to the continuum so early detection leads not only to diagnosis and treatment review, but also to practical risk-reduction action that communities can see and measure.

- If you lead a health system, clinic, or plan: build closed-loop referrals, assign named owners for dementia workflows, train front-door staff, and measure follow-up, caregiver assessment, referral closure, avoidable emergency use, and family experience.
- If you work in technology or data: design tools that protect dignity, support consent, reduce caregiver burden, integrate with care plans, and help the system learn without turning people into data points.

- If you are a community leader, faith leader, employer, or neighbor: normalize early conversation, reduce stigma, support respite, make public spaces dementia-aware, and remind caregivers that accepting help is not weakness.
- If you are a reader with influence: share this story. Ask whether your community has a clear path from memory concern to evaluation, diagnosis, navigation, care planning, caregiver support, and follow-up. If the answer is no, help build it.

One action is a paddle. Many actions, aligned, can move a canoe across the channel.

The newest paddle is prevention made practical: not a lecture, not blame, but a supported brain-health recipe that gives families something hopeful to do today.

Closing Blessing



Photo: plumeria in Hawai'i - a quiet image of presence, dignity, and time. Source: Bgabel, public domain.

***To every reader, caregiver, policymaker, clinician, researcher, and friend:
may you be blessed with good health, good thinking, steady courage, and
the comfort of knowing that no family has to walk this path alone.***

***Hope is not a wish floating offshore. Hope is a canoe. Put your hand to the
paddle. Together, we can bring it in.***

Source Notes

These source notes support major factual statements used in the policy report and narrative. They are included for credibility and follow-up review. Scenario calculations in Sections 14 and 15 are illustrative and should not be represented as actuarial predictions or medical promises.

- User-provided HANAI Memory Network infographic, “Hawai‘i Memory Network,” used for the original HANAI program concept: one dementia care specialist in each county, one contracted memory clinic in each neighbor-island county, minimum clinic staffing, EOA coordination, and the \$3,000,000 annual budget concept.
- User-provided “Building America’s Alzheimer’s Continuum of Care” report and visual summary, used as the base document for the expanded continuum architecture.
- Alzheimer’s Association, 2026 Alzheimer’s Disease Facts and Figures. Used for more than 7 million Americans living with Alzheimer’s, more than 12 million unpaid caregivers, 19+ billion caregiver hours, \$409 billion in 2026 costs, and nearly \$1 trillion projected by 2050. <https://www.alz.org/alzheimers-dementia/facts-figures>
- FDA, “FDA Clears First Blood Test Used in Diagnosing Alzheimer’s Disease,” May 16, 2025. Used for Lumipulse indication, age 55+ symptomatic use, and diagnostic-aid framing. <https://www.fda.gov/news-events/press-announcements/fda-clears-first-blood-test-used-diagnosing-alzheimers-disease>
- FDA, “FDA Converts Novel Alzheimer’s Disease Treatment to Traditional Approval,” July 6, 2023. Used for Leqembi traditional approval, early-stage studied population, and amyloid-plaque mechanism. <https://www.fda.gov/news-events/press-announcements/fda-converts-novel-alzheimers-disease-treatment-traditional-approval>
- FDA, “FDA Approves Treatment for Adults with Alzheimer’s Disease,” July 2, 2024. Used for Kisunla approval and early symptomatic Alzheimer’s treatment framing. <https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-treatment-adults-alzheimers-disease>
- Alzheimer’s Impact Movement, “The Alzheimer’s Screening and Prevention (ASAP) Act.” Used for ASAP bill framing and Medicare coverage pathway for blood-based dementia screening tests. https://alzimpact.org/ASAP_Act
- Alzheimer’s Impact Movement, “AADAPT Act.” Used for AADAPT bill numbers and virtual dementia provider training purpose. <https://alzimpact.org/AADAPT>
- LegiScan, Hawai‘i HB1853 bill text. Used for HANAI Memory Network purpose, community-based specialists, clinical partnerships, public education, early detection, care coordination, and long-term support. <https://legiscan.com/HI/text/HB1853/id/3430290>
- Alzheimer’s Association / AIM Hawai‘i advocacy page. Used for Hawai‘i-specific framing including more than 31,000 Hawaiians living with Alzheimer’s, underdiagnosis concern, and \$3 million annual HANAI appropriation advocacy. <https://alzimpact.org/Hawaii>
- CDC, BOLD Infrastructure for Alzheimer’s Act. Used for public-health infrastructure framing: risk reduction, early detection and diagnosis, prevention of avoidable hospitalizations, and caregiving. <https://www.cdc.gov/aging-programs/php/bold/index.html>
- Alzheimer’s Association, National Alzheimer’s Project Act. Used for NAPA signing date and national plan framing. <https://www.alz.org/napa>

- CMS Innovation Center, GUIDE Model. Used for care coordination, care management, caregiver support, respite, 24/7 access, home-and-community focus, and goals to reduce hospitalization, emergency department use, post-acute care, and other costly expenditures.
<https://www.cms.gov/priorities/innovation/innovation-models/guide>
- Alzheimer's Association, Alzheimer's and Dementia Care ECHO Program. Used for ECHO dementia training framing, team-based approach, geographic barrier reduction, and timely diagnosis focus. <https://www.alz.org/professionals/health-systems-medical-professionals/echo-alzheimers-dementia-care-program>
- Project ECHO, ECHO Model. Used for "All Teach, All Learn" and hub-and-spoke learning model framing. <https://projectecho.unm.edu/model/>
- HL7 FHIR CarePlan and Observation documentation. Used for FHIR-ready data dictionary logic. <https://build.fhir.org/careplan.html> and <https://build.fhir.org/observation.html>
- Lancet Commission, "Dementia prevention, intervention, and care: 2024 report." Used for prevention/risk-reduction framing and 14 modifiable risk factors that may delay or prevent a substantial share of dementia cases. <https://www.thelancet.com/commissions-do/dementia-prevention-intervention-and-care>
- National Institute on Aging, active Alzheimer's and related dementias clinical trials. Used for the future-breakthrough section and the breadth of ongoing research.
<https://www.nia.nih.gov/research/ongoing-AD-trials>
- NIH Research Matters, "Blood test predicts start of Alzheimer's disease symptoms," March 17, 2026. Used for future biomarker scenario framing; not used as a current clinical-service recommendation. <https://www.nih.gov/news-events/nih-research-matters/blood-test-predicts-start-alzheimers-disease-symptoms>
- JAMA Internal Medicine / UCLA Alzheimer's and Dementia Care Program findings. Used for cautious financial logic that comprehensive dementia care may reduce long-term care admissions and may be cost neutral or cost saving depending on program costs.
<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2719196>
- Illustrations and photographs: Original small Hawai'i scene vignettes were retained. Real-scene Hawai'i photographs were inserted at selected story moments and resized/cropped/framed for layout without changing the narrative substance.
- Photo credit - Kaua'i coastline: U.S. Geological Survey / Climate Adaptation Science Centers, "Kaua'i," public domain. <https://www.usgs.gov/media/images/kauai>
- Photo credit - Haleakalā sunrise: National Park Service, "Haleakala sunrise from Kalahaku," public domain. https://commons.wikimedia.org/wiki/File:Haleakala_sunrise_from_Kalahaku.jpg
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- Photo credit - Hawaiian canoe in the cove: NPS Photo, "Canoe Rides in the Cove," public domain. [https://commons.wikimedia.org/wiki/File:Canoe_Rides_in_the_Cove_\(5abf6eca-eb8e-40da-8f82-4f3bb709f890\).jpg](https://commons.wikimedia.org/wiki/File:Canoe_Rides_in_the_Cove_(5abf6eca-eb8e-40da-8f82-4f3bb709f890).jpg)
- Photo credit - plumeria in Hawai'i: Bgabel, "Haw-plumeria," public domain.
<https://commons.wikimedia.org/wiki/File:Haw-plumeria.jpg>
- Music direction: For presentation or video production, use a licensed or royalty-cleared instrumental recording or arrangement of "Aloha 'Oe"; keep it soft enough that narration remains clear.

- Being Patient, “How Much Is an Alzheimer’s Blood Test?” Used for publicly reported self-pay price ranges for several Alzheimer’s blood biomarker tests and for the report’s illustrative \$500-\$1,500 uninsured cost range. <https://beingpatient.com/how-much-is-an-alzheimers-blood-test/>
- C2N Diagnostics / PrecivityAD Cost & Billing page. Used for patient-cost and financial-assistance framing for uninsured or uncovered patients. <https://precivityad.com/cost-billing>
- Mayo Clinic, “New blood tests for diagnosing Alzheimer’s disease.” Used for patient-facing explanation that blood tests are less invasive than PET or CSF testing but still part of a larger diagnostic evaluation. <https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/in-depth/new-blood-tests-alzheimers/art-20585060>
- FDA, “Premarket Notification 510(k).” Used for the meaning of FDA clearance and substantial equivalence. <https://www.fda.gov/medical-devices/premarket-submissions-selecting-and-preparing-correct-submission/premarket-notification-510k>
- FDA, “Premarket Approval (PMA).” Used for the description of PMA as the most stringent device marketing-application review for certain Class III devices. <https://www.fda.gov/medical-devices/premarket-submissions-selecting-and-preparing-correct-submission/premarket-approval-pma>
- FDA, “De Novo Classification Request.” Used for the description of De Novo as a pathway for novel low- or moderate-risk devices without a legally marketed predicate. <https://www.fda.gov/medical-devices/premarket-submissions-selecting-and-preparing-correct-submission/de-novo-classification-request>
- FDA, “Emergency Use Authorization.” Used to distinguish EUA from ordinary approval or clearance. <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization>
- FDA, “Breakthrough Devices Program.” Used to explain that Breakthrough Device designation can speed development and review but is not itself marketing authorization. <https://www.fda.gov/medical-devices/how-study-and-market-your-device/breakthrough-devices-program>
- FDA, Leqembi prescribing information, revised August 2025. Used for LEQEMBI IQLIK maintenance dosing, subcutaneous autoinjector instructions, patient/caregiver administration, storage, and safety language. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761375s000lbl.pdf
- FDA, “Advancing Health Through Innovation: New Drug Therapy Approvals 2025.” Used for FDA’s description of Leqembi Iqlik as a subcutaneous maintenance treatment after at least 18 months of IV Leqembi, allowing home administration by a patient or caregiver. <https://www.fda.gov/media/190705/download>
- FDA Drug Safety Communication, “FDA to recommend additional, earlier MRI monitoring for patients with Alzheimer’s disease taking Leqembi (lecanemab).” Used for ARIA-E monitoring and early MRI safety framing. <https://www.fda.gov/drugs/drug-safety-communications/fda-recommend-additional-earlier-mri-monitoring-patients-alzheimers-disease-taking-leqembi-lecanemab>
- FDA 510(k) K252163 decision summary for Roche Elecsys Phospho-Tau (181P) Plasma. Used for primary-care initial-assessment/rule-out framing for a cleared pTau181 plasma test. https://www.accessdata.fda.gov/cdrh_docs/reviews/K252163.pdf

Alzheimer’s Association, “New Alzheimer’s Association Report: Americans Want Early Diagnosis, Treatment and Are Open to Risk-Taking to Slow Disease Progression,” April 29, 2025. Used for the

survey finding that 79% of Americans surveyed would want to know if they had Alzheimer's disease before symptoms or before symptoms interfered with activities; 91% would want a simple test such as a blood biomarker test; 92% would probably or definitely want medication to slow progression after diagnosis; and 58% would accept moderate to very high risk to take medication in the early stages. <https://www.alz.org/news/2025/facts-figures-report-alzheimers-treatment>

Baker LD et al., "Structured vs Self-Guided Multidomain Lifestyle Interventions for Global Cognitive Function: The U.S. POINTER Randomized Clinical Trial," JAMA, July 28, 2025. Used for the 2,111-participant, five-site, two-year randomized clinical trial design and the conclusion that the structured higher-intensity intervention had a statistically significant greater benefit on global cognition than the self-guided intervention. <https://jamanetwork.com/journals/jama/fullarticle/2837046>

Alzheimer's Association / AAIC 2025 press release, "U.S. POINTER Study Shows Structured Lifestyle Program Targeting Multiple Risk Factors Improves Cognition in Older Adults at Risk of Cognitive Decline," July 28, 2025. Used for trial framing, high adherence and safety, consistent cognitive benefits across major subgroups, and the implementation message that lifestyle programs must be tailored to local environments. <https://aaic.alz.org/releases-2025/us-pointer-study-results-announced.asp>

Alzheimer's Association, "U.S. POINTER | Study Results." Used for the finding that two multidomain lifestyle interventions improved cognition in older adults at risk of cognitive decline, with greater benefit in the more structured intervention, and for the brain-health recipe of physical exercise, cognitive/social engagement, nutrition, and health monitoring. <https://www.alz.org/us-pointer/study-results>

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Contact & Additional Information

For additional information, use the pathway below. This page is designed as the practical last page of the report: who to contact, where to look first, and which resource fits which need.

Hawai'i Memory Network / Alzheimer's Association Hawai'i public-policy contact: Coby Chock, Hawaii Director of Public Policy & Advocacy | 808.451.3410 | ckchock@alz.org

What you want to do	Where to go first	Website / contact
Learn about Alzheimer's disease, dementia warning signs, care options, and family education	Alzheimer's Association	alz.org
Follow federal Alzheimer's advocacy and policy opportunities including ASAP and AADAPT	Alzheimer's Impact Movement	alzimpact.org
Understand the CMS GUIDE dementia-care navigation model	Centers for Medicare & Medicaid Services	CMS GUIDE Model page
Review public-health infrastructure for dementia risk reduction, early detection, and caregiver support	CDC BOLD Infrastructure for Alzheimer's Act	CDC BOLD Infrastructure page
Track Hawai'i HANAI legislation and statutory language	LegiScan HB1853 / Hawai'i legislative history	LegiScan HB1853 page
Review Hawai'i's Alzheimer's Disease and Related Dementias state-plan context	Hawai'i State Strategic Plan on ADRD	Hawai'i ADRD State Plan PDF
Check FDA information on Alzheimer's diagnostic aids and approved treatments	U.S. Food and Drug Administration	FDA website
Understand the interoperability language behind FHIR-ready care plans and observations	HL7 FHIR	HL7 FHIR website
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Good health, good thinking.