

Alzheimer's and Dementia in Hawai'i

The Present Crisis—and the Future Hawai'i Faces If We Fail to Act

Updated July 24, 2026

Hawai'i is not facing a static number. It is facing a moving wave.

Prepared by

Jerry Perone

Honolulu, Hawai'i

Copyright © 2026 Jerry Perone. All Rights Reserved.

ONE SIMPLE WAY OUR ROTARY CLUB CAN HELP NOW

Form a Rotary team, make a donation, and join the 2026 Walk to End Alzheimer's.

It is one immediate, practical way to stand with Hawai'i families living with Alzheimer's and dementia.

SATURDAY, NOVEMBER 7, 2026 • MAGIC ISLAND

THE HAWAII DEMENTIA CLOCK

The Count Is Moving—Not Standing Still

A policy-planning snapshot for July 2026

36,000–40,000 People age 65+ living with clinical Alzheimer's today ^[2–4] Updated planning range; not a live registry count	51,000–66,000 People age 65+ living with all forms of dementia ^[3–5] Includes Alzheimer's; the two figures must not be added
≈16 each day New clinical Alzheimer's cases ^[3,4] ≈5,800 per year—or roughly one every 90 minutes	≈23–26 each day New cases of all-cause dementia ^[3–5] ≈8,300–9,600 per year—or one every 55–64 minutes

OFFICIAL PUBLISHED BENCHMARK

The Alzheimer's Association's state estimate is 31,200 Hawai'i residents age 65 and older with clinical Alzheimer's dementia in 2020—11.3% of adults over 65. Governor Green described the current burden as more than 31,000 when signing Act 245 in July 2026. Hawai'i does not yet maintain a real-time dementia registry, so the more current figures above are transparent planning estimates rather than daily head counts. ^[1,2]

62,000 Unpaid dementia caregivers ^[2]	111 million Hours of unpaid care each year ^[2]	\$3.3 billion Annual value of unpaid care ^[2]
--	---	--

Interpretation note. Incidence means the estimated biological or clinical onset of a new case—not necessarily the day a clinician formally records the diagnosis. Daily incidence is not the same as net growth in prevalence because deaths, migration, diagnostic delays, and disease progression also change the total. Estimates exclude most younger-onset cases and may therefore be conservative.

FROM COMMUNITY NEED TO STATE LAW

The Hānai Memory Network Is Now Law

On July 14, 2026, Governor Josh Green signed House Bill 1853 into law as Act 245. The law establishes the Hānai Memory Network Program—Hawai‘i’s Assistance for the Navigation of Alzheimer’s Intervention—within the Executive Office on Aging and appropriates \$3 million for implementation. It is the state’s first dedicated, statewide delivery architecture for dementia screening, diagnosis, care navigation, caregiver support, and community clinical linkages.^[1,6]

How HB 1853 became Act 245

DATE	MILESTONE	WHY IT MATTERED
2023–25	Hawai‘i 2035 plan and coalition work	The state established a public-health blueprint, stakeholder coalition, and priorities for early detection, workforce, data, caregiver support, and community-clinical linkages.
Jan. 26	HB 1853 introduced and referred	The proposal entered the 2026 Legislature with a companion measure, SB 2269.
Feb. 6	House Health and Human Services hearing	People living with dementia, caregivers, clinicians, aging organizations, and advocates testified about delayed diagnosis, neighbor-island barriers, and family burden.
Feb. 27	House Finance approval	The financing and implementation framework moved forward without a dissenting committee vote.
Mar.–Apr.	Senate HHS and WAM approval	The Senate refined the bill and advanced it through health and budget review.
May 1	Conference Committee agreement	House and Senate negotiators approved the CD1 version.
May 6	Final passage in both chambers	The House and Senate passed the conference draft unanimously; it was transmitted to the governor.
July 14	Signed as Act 245	The Hānai Memory Network became law with a \$3 million appropriation.

“HB1853 matters because it builds the map families do not have today.”

— Jerry Perone, testimony in strong support of HB 1853, February 6, 2026^[7]

WHAT THE LAW CHANGES FOR FAMILIES

How Act 245 will benefit people across Hawai‘i

- **Earlier, more consistent entry into care.** Dedicated dementia care specialists can help turn a memory concern into an assessment, referral, and care plan rather than a months-long search for the right door.
- **Neighbor-island access.** Community-based memory clinics reduce the need for repeated interisland travel and bring assessment and follow-up closer to home.
- **Coordinated handoffs.** The network is designed to link community referrals, primary care, specialists, treatment, caregiver support, and long-term services instead of leaving families to assemble the system alone.
- **Caregiver support.** Families can receive navigation, education, planning, and connections to respite and community resources before exhaustion becomes an emergency.
- **Equity and cultural responsiveness.** Local delivery can be shaped around language, culture, geography, and the documented needs of Native Hawaiian and Pacific Islander communities, rural residents, and multigenerational ‘ohana.^[8,11]
- **Lower crisis utilization.** Earlier diagnosis and coordinated care are intended to reduce preventable emergency-department visits, hospitalizations, and avoidable institutional placement.^[1,8]

Important distinction: the policy infographic envisioned a recurring annual network budget supported by state appropriations and Medicaid reimbursement. Act 245 provides the initial \$3 million appropriation; sustained operations, contracting, reimbursement, staffing, performance measurement, and future appropriations will determine whether the law becomes a durable statewide system.^[1,8]

How Hānai is intended to work

1 A concern enters A resident, family member, community organization, or primary-care practice identifies a memory concern and reaches a county access point.	2 A dementia care specialist responds The county specialist helps triage the concern, gathers information, supports the family, and coordinates the next appropriate handoff.
3 Clinical assessment and diagnosis A primary-care clinician, geriatrician, neurologist, or neighbor-island memory clinic evaluates, stages, and explains findings and options.	4 Treatment, navigation, and long-term support The network links clinical treatment with caregiver support, safety planning, home services, respite, community programs, and long-term care.
THE DESIGN PRINCIPLE No wrong door. Wherever a resident first asks for help, the system should know the next step, make the handoff, and remain responsible until the connection is complete.	

Executive Summary

THE CENTRAL FINDING

Hawai'i has moved from recognizing dementia as a growing problem to building a statewide response. Act 245 supplies the missing delivery framework. The federal ASAP and AADAPT bills could strengthen screening and provider capacity upstream. The decisive challenge now is execution: connecting prevention, detection, diagnosis, treatment, care navigation, caregiver support, long-term services, and end-of-life care into one functioning continuum.

Alzheimer's disease and related dementias are already a public-health, workforce, economic, caregiving, and family-security crisis in Hawai'i. The state's official published benchmark is 31,200 residents age 65 and older with Alzheimer's in 2020. Because Hawai'i's 65-and-older population rose from approximately 283,000 in 2020 to 324,150 in 2025—and because risk rises steeply with age—a defensible July 2026 planning range is approximately 36,000 to 40,000 older adults living with clinical Alzheimer's and approximately 51,000 to 66,000 living with all forms of dementia. These estimates are not a registry count; they are an uncertainty band built from official state demographics and national epidemiologic rates. ^[2-5]

The number is not stationary. Applying published age-specific incidence rates to Hawai'i's current age structure produces an estimated 5,800 new clinical Alzheimer's cases per year—about 16 per day. If Alzheimer's accounts for 60% to 70% of dementia, the corresponding planning estimate for all-cause dementia is approximately 8,300 to 9,600 new cases per year, or 23 to 26 per day. In practical terms, another Hawai'i family may begin the dementia journey roughly every hour. ^[3-5]

The human burden extends far beyond the person with the diagnosis. Approximately 62,000 unpaid caregivers provide 111 million hours of care annually, valued at \$3.3 billion. Nearly two-thirds report chronic health conditions; 16.6% report depression; and 11.9% report poor physical health. Hawai'i's formal care system rests on an enormous, largely invisible labor force of spouses, children, relatives, friends, and neighbors. ^[2]

The state's clinical and long-term-care capacity is thin. Hawai'i reported only 83 geriatricians in the latest state profile. People with dementia generated 1,248 emergency-department visits per 1,000 people in the cited utilization year, and dementia-related hospital readmissions were 16%. Separate state planning documents warn of a critical direct-care-worker shortage made worse by housing costs, low wages, geographic fragmentation, and the difficulty of recruiting and retaining workers. ^[2,12]

Act 245 changes the strategic position. Hānai places dementia care specialists in counties, supports memory clinics on neighbor islands, coordinates through the Executive Office on Aging, and is intended to connect community and primary-care pathways with assessment, treatment, care planning, and caregiver support. It is not a cure and it does not replace hospitals, health plans, or long-term-care services. It is the statewide connective tissue that Hawai'i has lacked. ^[1,8]

Two pending federal bills could make that connective tissue more effective. The Alzheimer's Screening and Prevention Act—ASAP, H.R. 6130/S. 3267—would create a Medicare pathway for coverage of appropriate blood-based Alzheimer's screening. The Accelerating Access to Dementia and Alzheimer's Provider Training Act—AADAPT, H.R. 3747/S. 4036—would reauthorize and strengthen Project ECHO-style virtual training so primary-care teams can identify, diagnose, and manage dementia more effectively, particularly in rural and underserved communities. As of July 24, 2026, ASAP remains pending; the House passed AADAPT on July 20, and further congressional action is required. ^[14-16]

Together, the architecture is compelling: AADAPT can prepare the front door; ASAP can open the screening door; Hānai can provide the statewide hallway, navigation, and handoffs; CMS GUIDE, health systems, the Aging and

Disability Resource Center, Area Agencies on Aging, home- and community-based services, long-term care, palliative care, and hospice can carry people and caregivers through the remaining stages.^[9,10,13-16]

The doomsday scenario is not that every resident develops dementia. It is that too many people develop it at the same time, too few are diagnosed early, too few families receive support, too few workers are available, and the state responds only after each household reaches collapse. In that scenario, emergency departments become the default safety net, hospitals cannot discharge patients safely, caregivers become patients, memory-care capacity is rationed, household assets disappear, and public spending rises because Hawai'i pays for crises rather than continuity.

That future is not inevitable. Hawai'i now has a law, a strategic plan, a coalition, public-health infrastructure, a CMS GUIDE site, caregiver programs, research capacity, and a defined federal policy agenda. The next task is to make the continuum real in every county—with measurable access, culturally responsive care, sustainable financing, an adequately paid workforce, and accountability for outcomes.

THE POLICY IMPERATIVE

Hawai'i does not need another disconnected program. It needs a functioning continuum in which federal screening and provider-training policy feeds a state network that can diagnose, treat, navigate, support caregivers, and connect people to long-term services.

Four immediate operating priorities

1 Implement Act 245

Define the statewide service package, county coverage, contracts, referral standards, data, performance measures, and sustainable financing.

2 Build the federal–state bridge

Prepare Hānai and health systems so covered blood-based screening under ASAP and provider training under AADAPT lead to completed care—not a dead end.

3 Protect caregivers

Make assessment, training, respite, crisis backup, workplace support, and navigation routine parts of every care plan.

4 Build workforce and accountability

Recruit and retain clinicians and direct-care workers, publish equity measures, and report time to assessment, diagnosis, treatment, and avoidable crisis use.

Contents

1	Understanding the numbers: prevalence, incidence, and uncertainty
2	The current Alzheimer's and dementia situation in Hawai'i
3	The caregiving crisis
4	A health system and workforce under pressure
5	Equity, culture, geography, and Native Hawaiian and Pacific Islander communities
6	The financial burden
7	Hawai'i's continuum of care: how Hānai, ASAP, and AADAPT fit together
8	The doomsday scenario if Hawai'i does not find answers
9	A quantitative stress test
10	What Hawai'i must do now
A	Appendix A: Methodology for the July 2026 planning estimates
B	Appendix B: Continuum-of-care crosswalk
R	References and source notes

Scope note. This report focuses on the population age 65 and older when estimating prevalence and incidence because the best comparable data are organized by those age groups. Younger-onset Alzheimer's and other dementias remain important but are not fully represented in the modeled totals.

1. Understanding the Numbers

Prevalence is the number living with disease; incidence is the flow of new cases into that population.

1.1 Three different numbers answer three different questions

The phrase “how many cases do we have today?” sounds simple, but it can refer to three different measures. A reliable report must keep them separate.

1. **Published prevalence benchmark.** The Alzheimer's Association estimates 31,200 Hawai'i residents age 65 and older had clinical Alzheimer's dementia in 2020. This is the official state-specific benchmark used in the 2026 state profile.^[2]
2. **Current planning estimate.** Hawai'i's older population has grown and aged since 2020. Updating the benchmark by demographic growth and applying national age-specific prevalence rates produces a plausible July 2026 range of approximately 36,000 to 40,000 older adults with clinical Alzheimer's.^[3,4]
3. **All-cause dementia estimate.** Alzheimer's is the most common cause and contributes approximately 60% to 70% of dementia cases. Converting the Alzheimer's range accordingly yields a broad planning range of roughly 51,000 to 66,000 older adults with dementia from all causes.^[5]

DO NOT ADD THE ALZHEIMER'S AND ALL-DEMENTIA TOTALS

Alzheimer's cases are already included within the all-cause dementia estimate. The all-dementia number also includes vascular dementia, Lewy body dementia, frontotemporal dementia, mixed dementia, and other causes.

1.2 Why the number changes every day

The population living with dementia is a moving stock. It changes as new cases begin, existing cases progress, residents move into or out of the state, diagnoses are made or missed, and people die. A prevalence figure is therefore a snapshot, not a permanent count.

- **New incidence** adds people to the population living with disease.
- **Mortality** removes people from the population, although Alzheimer's may be under-recorded on death certificates.
- **Migration** matters in an island state, especially among retirees and families who relocate for care.
- **Diagnosis lag** means biological disease may exist years before the health system recognizes or records it.
- **Improved screening** can make recorded prevalence rise even if underlying disease risk has not suddenly changed.

1.3 Estimated new cases by age

Planning model for new clinical Alzheimer's cases among Hawai'i residents age 65+

Age	2025 population	Estimated prevalence	Annual incidence	New cases/year	New cases/day
65-74	171,837	5.2%	0.4%	≈652	≈1.8
75-84	108,650	13.8%	3.2%	≈2,997	≈8.2
85+	43,663	35.8%	7.6%	≈2,130	≈5.8
TOTAL	324,150	—	—	≈5,779	≈15.8

Method: The model subtracts estimated prevalent Alzheimer's cases from each age cohort to approximate the population still at risk, then applies published annual incidence rates. Those incidence rates were derived from an older national cohort, and the 2026 Facts and Figures report states that current incidence would likely be higher if updated estimates were available. The estimate should therefore be used for capacity planning—not as a count of people formally diagnosed on a particular day.^[3,4]

1.4 What the daily flow means operationally

An estimated 16 new Alzheimer's cases per day means approximately 112 per week and nearly 500 per month. For all dementias, 23 to 26 new cases per day means approximately 160 to 185 per week and 690 to 790 per month.

Every one of those cases creates a future need for assessment, counseling, care planning, medication management, driving and home-safety decisions, caregiver education, and—eventually for many—hands-on personal care.

The operational question is therefore not simply whether Hawai'i can diagnose 36,000 to 40,000 people. It is whether the state can absorb a continuing daily inflow while still supporting everyone already living with the disease.

2. The Current Situation in Hawai'i

2.1 Hawai'i is especially vulnerable because it is an aging state

Hawai'i's July 2025 population estimate was approximately 1.43 million. Of those residents, 324,150—22.6%—were age 65 or older. The oldest age groups are growing fastest: the 75-to-84 population rose from about 79,000 in 2020 to nearly 109,000 in 2025, while the 85-and-older population grew from approximately 37,900 to 43,700.^[4]

Longevity is a triumph. It also creates predictable care demand because age is the strongest risk factor for Alzheimer's dementia. National prevalence rises from 5.2% at ages 65–74 to 13.8% at 75–84 and 35.8% at age 85 and older. As more residents enter their eighties and nineties, the absolute number living with dementia will rise unless prevention and treatment materially change the trajectory.^[3]

2.2 The official count is substantial—and under-recognizes the full burden

The 31,200 official state benchmark is limited to clinical Alzheimer's dementia among people age 65 and older. It does not fully capture younger-onset disease, other dementias, people whose symptoms have not been recognized, or people whose cognitive impairment is recorded under another diagnosis. It also does not capture the many family members whose lives are reorganized around the disease.^[2]

Underdiagnosis is not a statistical technicality. It means people miss opportunities for reversible-cause evaluation, risk reduction, legal and financial planning, caregiver preparation, clinical trials, safety interventions, and time-sensitive treatment.

2.3 Mortality is rising

Alzheimer's disease was Hawai'i's fifth-leading cause of death in the 2026 state profile. The state recorded 509 Alzheimer's deaths in 2024, and recorded Alzheimer's mortality increased 331.4% between 2000 and 2024.^[2]

Even that figure can understate the disease's role. Advanced dementia contributes to aspiration, pneumonia, falls, malnutrition, dehydration, infections, and frailty. A death certificate may record one of those immediate causes without fully reflecting the underlying neurodegenerative disease.

2.4 Emergency and hospital use reveal system strain

The state profile reports 1,248 emergency-department visits per 1,000 people with dementia and a 16% hospital readmission rate in the cited years. Because some people have multiple visits while others have none, the rate does not mean that every person visited an emergency department. It does show that dementia is associated with repeated high-cost, high-stress encounters.^[2]

Emergency departments are poorly designed for cognitive vulnerability. Noise, unfamiliar surroundings, disrupted routines, long waits, and multiple handoffs can worsen confusion and delirium. Yet families often have no alternative when a person falls, wanders, becomes dehydrated, stops eating, misuses medication, or develops behavior that cannot be managed safely at home.

2.5 The diagnosis geography is unequal

Hawai'i's island geography turns ordinary care fragmentation into a structural barrier. Specialty services are concentrated on O'ahu. Neighbor-island residents may face travel costs, time away from work, interisland flights,

transportation from airports, and repeated visits for diagnostic confirmation, treatment, or monitoring. The University of Hawai‘i’s 2026 review identified limited neighbor-island access as one of the state’s major dementia needs.^[11]

Act 245 directly addresses this gap by placing dementia care expertise in each county and establishing community-based memory clinics on the neighbor islands. The benefit is not simply convenience. Local access can determine whether a person is diagnosed early enough to plan, participate in treatment decisions, and remain safely at home longer.^[1,8]

3. The Caregiving Crisis

3.1 Hawai‘i’s dementia system is built on unpaid labor

Approximately 62,000 family members and friends provide unpaid dementia care in Hawai‘i. Together they contribute 111 million hours annually, valued at approximately \$3.3 billion. Hawai‘i ranks fourth among the states in average hours of care per caregiver.^[2]

What 111 million unpaid-care hours means

Every day	≈304,000 hours of unpaid care
Every hour	≈12,700 hours of unpaid care
Full-time workforce equivalent	≈53,000 workers at 2,080 hours per year
Average per identified caregiver	≈1,790 hours per year—or about 34 hours per week

Calculated from the Alzheimer’s Association’s 111-million-hour estimate; figures are rounded.^[2]

3.2 Care expands by stages

Dementia caregiving rarely begins with twenty-four-hour supervision. It expands in layers, often so gradually that families do not recognize how much of their lives have been absorbed.

- **Early stage:** reminders, transportation, appointment coordination, bill review, medication setup, and emotional support.
- **Middle stage:** daily medication supervision, meal preparation, driving cessation, wandering prevention, hygiene assistance, and management of repetitive or distressed behavior.
- **Advanced stage:** transfers, toileting, bathing, feeding, incontinence care, pressure-injury prevention, aspiration risk management, and overnight observation.

3.3 The caregiver becomes the second patient

Among Hawai‘i’s dementia caregivers, 61.7% report chronic health conditions, 16.6% report depression, and 11.9% report poor physical health. Sleep loss, social isolation, back injuries, missed medical care, financial strain, and persistent vigilance can transform a healthy spouse or adult child into a second person needing care.^[2]

THE SHADOW PATIENT

Every person with dementia may create a second patient: the unpaid caregiver whose physical health, mental health, employment, retirement security, and relationships deteriorate under sustained responsibility.

3.4 Caregiving is also a workforce and economic problem

Caregivers arrive late, leave early, reduce hours, decline promotions, use leave, or resign. Employers lose experienced workers and institutional knowledge. Families lose wages, Social Security credits, retirement

contributions, and health insurance stability. The effects extend far beyond the household and are not fully captured in healthcare budgets.

A functioning continuum must therefore treat caregiver support as core infrastructure—not an optional social service. Training, respite, counseling, legal and financial navigation, emergency backup, and workplace flexibility can determine whether a person remains at home safely or enters institutional care after a preventable crisis.

4. A Health System and Workforce Under Pressure

4.1 Specialist capacity is limited

Hawai'i reported 83 geriatricians in the most recent state profile. Dementia care also depends on neurologists, geriatric psychiatrists, neuropsychologists, primary-care clinicians, advanced-practice nurses, registered nurses, social workers, pharmacists, rehabilitation professionals, care navigators, and direct-care workers. A shortage in any link can delay the entire pathway.^[2]

The most important capacity problem may not be the number of specialists alone. It is the absence of an organized pathway that lets primary care know what to do, allows specialists to focus on complex cases, and gives families a navigator who remains responsible for the handoffs. This is the systems problem that Hānai is designed to address.

4.2 Direct-care shortages threaten aging in place

The state's long-term-care workforce plan describes a critical shortage of direct-care workers—nursing assistants, home health aides, personal-care aides, and others who provide hands-on assistance. Hawai'i's high cost of living, housing shortage, inflation, low wages, and limited benefits make recruitment and retention especially difficult. The report warns that without enough well-trained workers, kūpuna and people with disabilities will not receive the level of support needed to age with dignity.^[12]

Dementia magnifies this shortage because the work is relational, continuous, and behaviorally complex. A person may be physically strong yet unable to remember instructions, recognize danger, tolerate a new caregiver, or communicate pain. Staffing ratios that appear adequate for routine assistance may fail when one resident wanders, resists care, or requires constant redirection.

4.3 Hospitals inherit problems created outside the hospital

When home support fails, the emergency department and hospital become the default. The immediate medical problem may be treated, but discharge can become impossible when the person cannot live alone, the caregiver has collapsed, no home-care worker is available, and no residential bed will accept the patient.

This creates a systemwide cascade: emergency-department boarding, delayed admissions, longer lengths of stay, postponed procedures, ambulance delays, and higher costs for people whose primary need is safe supervision and coordinated placement—not acute hospital treatment.

4.4 Existing assets can be connected rather than duplicated

Hawai'i already has important pieces: the Executive Office on Aging, the statewide Aging and Disability Resource Center, county Area Agencies on Aging, caregiver information and assistance, counseling, support groups, training, respite, and supplemental services. Straub Benioff Medical Center participates in the CMS GUIDE model, which provides comprehensive assessment, social-work navigation, 24/7 advice, and respite referral for eligible participants. Hānai should connect these assets—not create a parallel maze.^[10,13]

5. Equity, Culture, and Geography

5.1 Why Native Hawaiian and Pacific Islander equity must be explicit

A University of Hawai'i report identifies Native Hawaiian and Pacific Islander disparities as a central state need. It cites an age-adjusted dementia incidence estimate of 20 per 1,000 person-years and a 25-year cumulative risk of 25% beginning at age 65 in one study. It also summarizes research indicating younger diagnosis, greater cognitive impairment at diagnosis, and higher burdens of hypertension, hyperlipidemia, and type 2 diabetes in a Hawai'i clinic sample.^[11]

These findings come from particular studies and clinical populations; they should not be treated as a complete statewide registry. They are nevertheless strong enough to make equity a design requirement. A statewide system that performs equally on average can still fail Native Hawaiian, Pacific Islander, rural, low-income, and limited-English-proficiency communities.

5.2 What culturally responsive care requires

- Community-based access points trusted by local residents, including community health centers, faith communities, cultural organizations, and Native Hawaiian health systems.
- Communication that respects family decision-making, language preference, cultural concepts of aging, and the role of multigenerational 'ohana.
- Risk-reduction programs that address hypertension, diabetes, hearing, physical activity, social connection, sleep, and nutrition in culturally relevant ways.
- Research recruitment and validation that include Hawai'i's diverse populations so diagnostic tools and treatments are not simply imported from less representative cohorts.
- Transportation, telehealth, and island-specific workflows that do not assume every resident can reach Honolulu repeatedly.

5.3 How Hānai can improve equity

Hānai is statewide; it is not limited to Native Hawaiians. Its equity value comes from how it is implemented. County-based dementia care specialists and neighbor-island memory clinics can reduce the distance between the first concern and appropriate care. If contracts include cultural competence, language access, community outreach, transportation coordination, data stratification, and measurable service standards, Act 245 can narrow rather than reproduce existing gaps.^[1,8,11]

EQUITY TEST FOR IMPLEMENTATION

Success should be measured not only by how many people enter Hānai, but by whether time to assessment, diagnostic completion, treatment access, caregiver support, and avoidable hospital use improve across islands, races and ethnicities, languages, income groups, and rural communities.

6. The Financial Burden

6.1 Public spending is already substantial

The 2026 state profile estimates \$323 million in Hawai'i Medicaid costs for people with Alzheimer's in 2025 and \$27,460 in per-capita Medicare spending for people with dementia. These figures do not include the full value of unpaid care, lost wages, private memory-care payments, home modifications, legal planning, transportation, or the health costs borne by caregivers.^[2]

6.2 Families discover the custodial-care gap

Medicare pays for medically necessary care under defined rules; it does not provide unlimited long-term custodial supervision. Families often learn this distinction only when a loved one can no longer be left alone. The household then pays for home-care aides, adult day programs, respite, assisted living, memory care, or nursing care—often for years.

A financially stable household can move through a predictable sequence: a spouse reduces work; savings fund home care; retirement plans are interrupted; assets are spent down; the caregiver becomes unable to continue; residential placement is sought; and Medicaid becomes the payer after financial eligibility requirements are met.

6.3 Hānai's \$3 million appropriation must be judged against the scale of the burden

The initial \$3 million appropriation is approximately 0.9% of the state's reported annual Medicaid Alzheimer's cost and less than one-tenth of one percent of the annual value of unpaid care. These comparisons do not prove a specific return on investment, but they put the implementation investment in perspective.^[1,2]

Measure	Annual scale	Hānai comparison
Initial Act 245 appropriation	\$3 million	Implementation base
Medicaid Alzheimer's costs	\$323 million	≈108 times larger
Value of unpaid dementia care	\$3.3 billion	≈1,100 times larger

6.4 The cost of waiting is not neutral

A delayed diagnosis can miss a treatment window, postpone driving and safety decisions, increase medication errors, and leave a caregiver unprepared. A delayed respite service can produce caregiver collapse. A delayed home-care placement can become an emergency admission. In dementia policy, failure to spend upstream does not eliminate cost; it transfers cost downstream to more expensive and more traumatic settings.

7. Hawai'i's Continuum of Care

How Hānai, ASAP, AADAPT, and existing state assets fit together

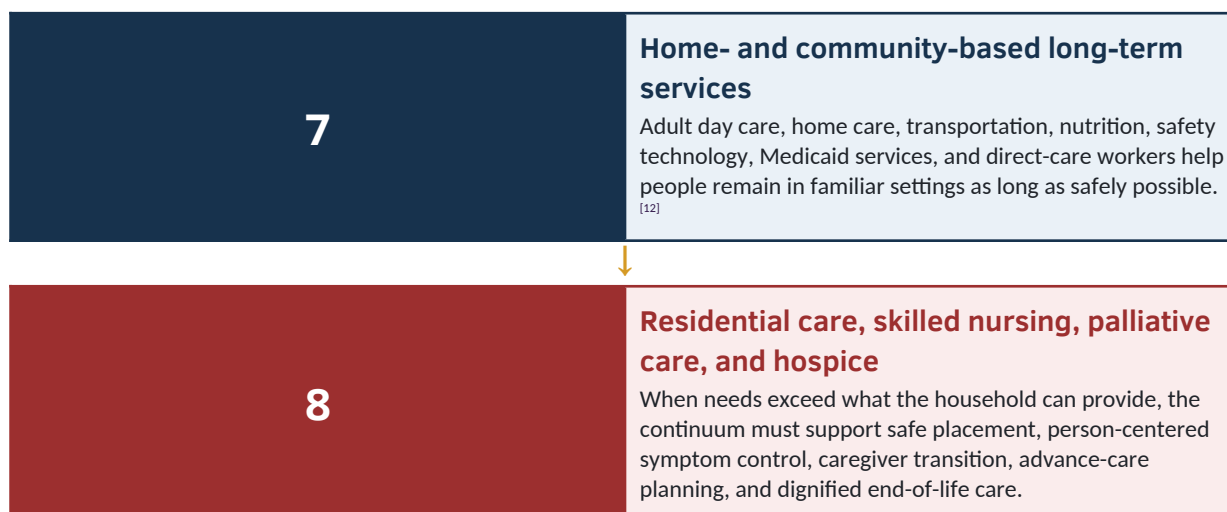
THE ONE-SENTENCE ARCHITECTURE

AADAPT prepares the front door; ASAP opens the screening door; Hānai builds the statewide hallway and handoffs; Hawai'i's existing aging, health-system, long-term-care, palliative, and hospice infrastructure carries people and caregivers through the rest of the journey.

7.1 A continuum—not a collection of disconnected programs

A true continuum of care begins before symptoms and continues through the final stage of life. It should be understandable to families, usable by primary care, connected to specialty treatment, responsive to culture and geography, and supported by financing and data. The most important design principle is a “no wrong door” system: whichever door a person enters, the system should know the next step and remain responsible for the handoff.





7.2 What ASAP would add

The bipartisan Alzheimer's Screening and Prevention Act, H.R. 6130/S. 3267, is designed to clear a Medicare coverage barrier for blood-based Alzheimer's screening. Earlier detection can create time for treatment, planning, clinical-trial participation, and support. The bill is pending as of July 24, 2026.^[14]

ASAP does not create memory clinics, navigators, confirmatory testing capacity, or treatment infrastructure. Without Hānai and health-system pathways, screening could identify risk without delivering a clear next step. The state and federal measures are therefore complementary.

7.3 What AADAPT would add

The AADAPT Act, H.R. 3747/S. 4036, would strengthen and reauthorize Project ECHO and dementia-focused virtual education. The House passed H.R. 3747 on July 20, 2026. As of July 24, further Senate and presidential action remained necessary.^[15,16]

For Hawai'i, the value is geographic leverage. Structured virtual mentorship can support primary-care clinicians on every island without requiring each community to recruit a full complement of specialists. Training can also make Hānai referrals more appropriate and improve shared management after diagnosis.

7.4 What Hānai adds that the federal bills do not

- A state accountable entity within the Executive Office on Aging.
- Dementia care specialists positioned by county.
- Community-based memory-clinic capacity on neighbor islands.
- A bridge between community pathways, primary care, specialists, treatment, caregiver services, and long-term care.
- A platform for consistent data, quality measures, equity monitoring, and statewide learning.

7.5 The missing implementation decisions

The law creates a program; implementation will determine whether it becomes a functioning network. Hawai'i will need clear answers to the following questions:

- What is the defined service package at each stage, and who is eligible?
- How quickly must a person receive triage, assessment, diagnostic work-up, and a care plan?
- How will contracts define staffing, language access, cultural responsiveness, telehealth, and island coverage?
- What services will Medicaid, Medicare, health plans, state appropriations, grants, and private pay finance?
- Which outcomes will be reported publicly—diagnosis time, treatment access, caregiver burden, emergency use, hospitalization, institutionalization, and equity?
- Who remains responsible when a person moves from one stage or payer to another?

8. The Doomsday Scenario

A systemic-failure scenario—not a prediction that every event will occur

WHAT “DOOMSDAY” MEANS IN THIS REPORT

Not a single catastrophic day. A slow cascade in which the number needing care grows faster than diagnostic capacity, workforce supply, caregiver endurance, residential capacity, and public financing—until crisis becomes the normal entry point to care.

1

The invisible wave

Thousands develop mild cognitive impairment or early dementia without recognition. They continue driving, managing medication, signing contracts, paying bills, using appliances, living alone, and caring for spouses. Diagnosis comes after a fall, scam, wandering episode, medication error, or avoidable hospitalization.

2

Families absorb the shock

Spouses and adult children compensate quietly. They begin with reminders and transportation, then take over finances, medication, meals, hygiene, and supervision. Work hours fall, savings are spent, sleep disappears, and family conflict grows. The state appears to be coping only because households are carrying the cost.

3

Emergency departments become the safety net

As home situations deteriorate, emergency departments receive falls, dehydration, delirium, wandering, behavioral crises, caregiver collapse, infection, malnutrition, and unsafe-discharge cases. Hospitals stabilize the immediate problem but cannot rebuild the household care system.

4

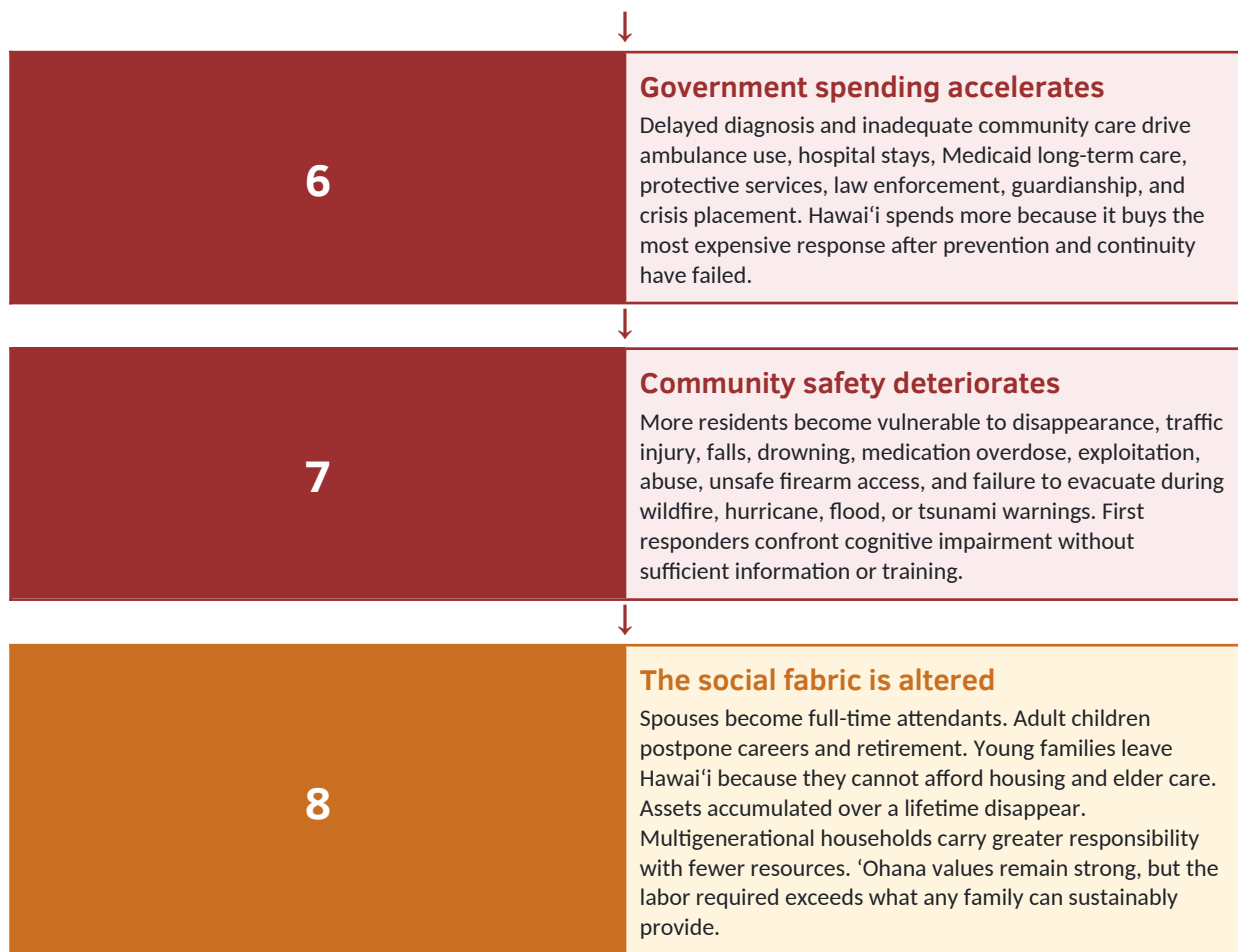
The workforce breaks

Home-care agencies cannot staff cases. Facilities close beds because workers cannot be recruited or retained. Experienced aides leave for higher wages or lower-cost states. Families willing to pay still cannot obtain reliable care, and neighbor-island shortages become extreme.

5

Long-term-care capacity is rationed by availability

Memory-care and nursing-home waiting lists lengthen. Facilities become more selective about residents with wandering, aggression, complex medical needs, Medicaid coverage, or no family advocate. People remain in unsafe homes or hospitals because no placement will accept them.



8.1 Why the cascade is plausible

Every element already exists in smaller form: underdiagnosis, high caregiver burden, frequent emergency use, specialist constraints, direct-care shortages, neighbor-island access gaps, and expensive long-term care. The scenario becomes “doomsday” when those pressures reinforce one another faster than the state builds capacity.

[2,11,12]

8.2 The disaster-response dimension

Dementia is also a resilience issue. During a wildfire, hurricane, flood, or tsunami warning, a person may not understand instructions, remember where medication is stored, tolerate a shelter, communicate identity, or remain separated from a caregiver. If the everyday care system is already operating at its limit, a major emergency can turn routine vulnerability into mass displacement and preventable loss.

Hānai should therefore interface with county emergency management, first-responder training, registries or voluntary emergency-information systems, evacuation planning, and continuity-of-care protocols. Dementia planning belongs in community resilience—not only in healthcare.

9. A Quantitative Stress Test

9.1 What a doubling could mean

Governor Green's Act 245 announcement states that the number of Hawai'i residents living with Alzheimer's is expected to double by 2050. Using the published 31,200 benchmark, a doubling would mean approximately 62,400 residents age 65 and older with Alzheimer's.^[1,2]

The table below is a proportional stress test—not an official forecast. It assumes today's caregiver ratio, unpaid-care hours, and unpaid-care valuation rise in direct proportion to the published Alzheimer's count. Actual outcomes will depend on prevention, treatment, mortality, migration, technology, workforce, wage inflation, and policy.

Measure	Current published scale	Doubling stress test
People age 65+ with Alzheimer's	31,200	≈62,400
Unpaid caregivers	62,000	≈124,000
Unpaid-care hours	111 million	≈222 million
Value of unpaid care	\$3.3 billion	≈\$6.6 billion in current-value terms
Medicaid cost	\$323 million	≈\$646 million if costs scaled proportionally

9.2 Why proportional growth could still understate the challenge

- The future population may contain more people in the highest-risk age groups, increasing average severity and care intensity.
- Caregiver availability may decline as families become smaller, relatives live farther away, and more older adults live alone.
- Labor, housing, insurance, transportation, and facility costs may rise faster than general inflation.
- Treatments that slow progression may increase the years during which people need monitoring and support, even while improving quality of life and delaying severe disability.
- Better diagnosis may reveal previously hidden need faster than service capacity can expand.

9.3 Why better answers can change the curve

The same mathematics works in the other direction. Delaying onset, preventing avoidable vascular injury, diagnosing earlier, slowing progression, strengthening caregivers, preventing crises, and postponing institutional placement can reduce the number of high-intensity care years. The objective is not merely to count disease more accurately; it is to change the timing, severity, and cost of the disease trajectory.

10. What Hawai‘i Must Do Now

10.1 Implement Act 245 as an accountable statewide network

- Publish an implementation charter with governance, county coverage, contracting milestones, service standards, referral pathways, and a public launch schedule.
- Define a minimum Hānai service package: triage, assessment, diagnostic coordination, care planning, caregiver needs assessment, navigation, and follow-up.
- Establish measurable access standards for response time, assessment completion, diagnostic completion, and care-plan delivery.
- Create a single statewide referral and tracking mechanism with warm handoffs and closed-loop communication to the referring clinician or community partner.
- Report outcomes by county, race and ethnicity, language, payer, and rurality to ensure equity.

10.2 Build the federal-state bridge

- Support enactment of ASAP while planning how covered biomarker screening would feed into counseling, confirmatory testing, staging, and treatment decisions in Hānai.^[14]
- Support final passage of AADAPT and prepare Hawai‘i health systems, community health centers, and Hānai clinics to use Project ECHO-style training.^[15,16]
- Coordinate Medicare, Medicaid, state appropriations, BOLD funding, health-plan payments, and grants so families are not stranded at payer boundaries.

10.3 Protect caregiver survival

- Make caregiver assessment part of every care plan and repeat it as disease severity changes.
- Expand respite, emergency backup, behavioral coaching, support groups, counseling, and legal and financial navigation.
- Develop employer guidance and incentives for flexible schedules, leave, and caregiver-friendly workplaces.
- Create a crisis threshold protocol so families receive intensive intervention before the emergency department becomes the only option.

10.4 Build and retain the workforce

- Use competitive wages, benefits, career ladders, apprenticeships, tuition support, and housing strategies to recruit and retain direct-care workers.^[12]
- Train primary-care teams, nurses, social workers, pharmacists, therapists, first responders, and direct-care staff in dementia capability.
- Use telehealth and virtual mentoring to extend specialist expertise while preserving local relationships and in-person capacity.

10.5 Treat data as infrastructure

- Create a privacy-protective statewide dementia data strategy that distinguishes screening, diagnosis, stage, service use, caregiver need, and outcomes.
- Update prevalence and incidence estimates regularly using Hawai‘i demographics and local data rather than repeating an old static figure.
- Track time to diagnosis, treatment eligibility, caregiver burden, avoidable emergency use, hospitalization, and institutional placement.

10.6 Invest in prevention and representative research

- Scale culturally relevant hypertension, diabetes, hearing, physical activity, sleep, nutrition, tobacco, and social-connection initiatives.
- Expand research participation among Native Hawaiian, Pacific Islander, Asian American, rural, and neighbor-island communities.
- Support blood-biomarker validation, treatment studies, caregiving research, and service-delivery trials that reflect Hawai‘i’s ethnic, cultural, and geographic characteristics.^[11]

Conclusion

Hawai'i has crossed an important threshold. The state is no longer discussing a hypothetical network; Hānai is law. The question is whether Act 245 will be implemented with the speed, financing, workforce, clinical partnerships, community trust, and accountability needed to match the moving wave.

The doomsday scenario is a failure of timing: the disease arrives before the system, the crisis arrives before the care plan, the hospital admission arrives before the home support, and caregiver collapse arrives before respite. The antidote is a functioning continuum that reaches people earlier and remains with them longer.

Alzheimer's disease takes memory one person at a time. A failed response would take something larger: the health of caregivers, the financial stability of families, the capacity of hospitals, and Hawai'i's ability to honor its kūpuna.

The time to build the system is not when the wave has already broken. It is now.

Appendix A. Methodology for the July 2026 Planning Estimates

A.1 Source populations

The U.S. Census Bureau's Vintage 2025 estimates, released in June 2026 and distributed through the Hawai'i State Data Center, report the following July 1, 2025 age-group populations: 171,837 at ages 65–74; 108,650 at ages 75–84; and 43,663 at age 85 and older. Total age 65+: 324,150.^[4]

A.2 Current Alzheimer's prevalence range

Method 1—demographic scaling. The official state benchmark of 31,200 Alzheimer's cases in 2020 is multiplied by the growth in the age-65+ population from 283,021 in 2020 to 324,150 in 2025. Result: approximately 35,734, rounded to 36,000.^[2,4]

Method 2—age-specific prevalence. The 2026 national prevalence rates of 5.2% at ages 65–74, 13.8% at ages 75–84, and 35.8% at age 85+ are applied to Hawai'i's 2025 age cohorts. Result: approximately 39,561, rounded to 40,000.^[3,4]

The report presents the two results as a planning range of 36,000 to 40,000 rather than selecting a false point estimate. The lower method preserves Hawai'i's state-specific baseline; the upper method captures the state's current age structure using national rates.

A.3 All-cause dementia prevalence range

The World Health Organization states that Alzheimer's disease contributes approximately 60% to 70% of dementia cases. Dividing the lower Alzheimer's estimate by 70% and the upper estimate by 60% produces an all-cause planning range of approximately 51,000 to 66,000 older adults.^[5]

This conversion assumes the WHO share applies reasonably to Hawai'i. The true share may differ by age, ethnicity, vascular risk, and diagnostic practices. The range also excludes many younger-onset cases.

A.4 Alzheimer's incidence

The 2026 Facts and Figures report cites annual incidence rates derived from the Chicago Health and Aging Project: 0.4% at ages 65–74, 3.2% at ages 75–84, and 7.6% at age 85+. For each age group, the model subtracts estimated prevalent Alzheimer's cases from the population to approximate the population at risk, then applies the incidence rate. The total is approximately 5,779 new cases annually, or 15.8 per day.^[3,4]

The national report notes that 2026 incidence would likely be higher if updated estimates were available. The resulting Hawai'i estimate should therefore be interpreted as an approximate planning rate, potentially conservative, rather than a precise surveillance statistic.

A.5 All-cause dementia incidence

For planning purposes, the Alzheimer's incidence estimate is divided by 70% and 60%, producing approximately 8,256 to 9,632 new all-cause dementia cases annually, or 22.6 to 26.4 per day. This assumes Alzheimer's comprises a similar share of incident dementia as prevalent dementia, which is an approximation.^[5]

A.6 Limitations

- No real-time statewide dementia registry exists; estimates cannot identify the exact number living with disease on July 24, 2026.
- Prevalence and incidence rates are national estimates applied to Hawai'i demographics and may not capture local racial, ethnic, socioeconomic, health, and migration patterns.
- The incidence rates derive from earlier cohort data.

- Younger-onset dementia is incompletely represented.
- All-cause estimates depend on the assumed 60%–70% Alzheimer's share.
- The planning range is designed for policy and capacity discussions—not individual diagnosis, clinical decision-making, or budget certification.

Appendix B. Continuum-of-Care Crosswalk

Stage	Hawai'i assets in place	Federal policy contribution	Implementation priority
1. Brain health	Hawai'i 2035; BOLD; Healthy Brain Tracker; community education	Federal public-health and research funding	Scale culturally relevant risk reduction; maintain current data
2. First concern	Primary care; community organizations; cognitive assessment initiatives	AADAPT: Project ECHO-style provider training	Standardized first-contact workflow and warm referral to Hānai
3. Screening	Existing clinical testing under current coverage rules	ASAP: Medicare pathway for appropriate blood-based screening	Counseling, eligibility, informed consent, and confirmatory pathway
4. Diagnosis/staging	Health systems; PCPs; geriatrics; neurology; memory services	AADAPT strengthens community clinician capacity	Hānai memory clinics and county specialists; time-to-diagnosis standards
5. Treatment	Specialty and primary care; infusion and imaging capacity	Federal Medicare coverage and treatment policy	Equitable island access, monitoring, shared-care protocols
6. Navigation/caregivers	EOA; ADRC; AAAs; support groups; GUIDE site	CMS GUIDE; federal caregiver and aging programs	Closed-loop navigation, caregiver assessment, respite, crisis plans
7. Home/community LTSS	Home care; adult day; transportation; Medicaid HCBS	Medicaid and Older Americans Act funding	Direct-care workforce, housing, reimbursement, quality standards
8. Residential/end of life	Assisted living; memory care; skilled nursing; palliative care; hospice	Medicare hospice; Medicaid LTSS	Capacity, transitions, advance-care planning, dignity and family support

Reading the crosswalk. ASAP and AADAPT are not substitutes for Hānai. They address federal coverage and provider-capacity barriers. Act 245 creates Hawai'i's state delivery architecture. Existing aging, healthcare, caregiver, and long-term-care systems provide the services to which the network must connect.

THREE DIFFERENT JOBS—ONE CONTINUUM

ASAP can remove a Medicare screening barrier. AADAPT can strengthen the clinicians at the front door. Hānai can make the statewide handoffs visible and accountable. Hawai'i's healthcare, aging, caregiver, and long-term-care systems must then deliver the actual services.

References and Source Notes

- [1] **Office of the Governor, State of Hawai'i.** *Governor Green Signs Legislation to Support Kūpuna Care and Strengthen AI Protections.* July 14, 2026. [Source](#) — HB 1853 signed as Act 245; Hānai established; \$3 million appropriated.
- [2] **Alzheimer's Association.** *Hawaii Alzheimer's Disease Facts and Figures 2026.* 2026. [Source](#) — State prevalence benchmark, caregiving, mortality, workforce, utilization, Medicare and Medicaid figures.
- [3] **Alzheimer's Association.** *2026 Alzheimer's Disease Facts and Figures.* 2026. [Source](#) — National age-specific prevalence and incidence rates; methodology context.
- [4] **U.S. Census Bureau / Hawai'i State Data Center.** *Annual Estimates of the Resident Population by Single Year of Age and Sex for Hawai'i: April 1, 2020 to July 1, 2025.* Released June 2026. [Source](#) — Vintage 2025 age-cohort population estimates used in the planning model.
- [5] **World Health Organization.** *Dementia Fact Sheet.* Updated July 3, 2026. [Source](#) — Alzheimer disease contributes approximately 60%–70% of dementia cases.
- [6] **Hawai'i State Legislature / LegiScan compilation.** *HB 1853 Legislative History: Relating to Dementia.* 2026. [Source](#) — Committee actions, conference agreement, final passage, and enactment history.
- [7] **Hawai'i State Legislature.** *HB 1853 Testimony to the House Committees on Health and Human Services & Homelessness.* February 6, 2026. [Source](#) — Community, clinical, caregiver, and advocate testimony, including Jerry Perone.
- [8] **Alzheimer's Association Hawai'i.** *Hawai'i Memory Network: Supporting 2026 Legislative Policy Initiatives.* August 28, 2025. [Source](#) — Policy infographic supplied by the user: county dementia specialists, neighbor-island clinics, pathways, staffing concept, and intended outcomes.
- [9] **Executive Office on Aging, Hawai'i Department of Health.** *2025 Biennial Update: Hawai'i 2035 State Strategic Plan on Alzheimer's Disease and Related Dementias.* 2025. [Source](#) — State blueprint, BOLD infrastructure, coalition work, data, prevention, early detection, workforce, and community-clinical linkages.
- [10] **Executive Office on Aging, Hawai'i Department of Health.** *Family Caregiver and Aging Services.* 2026. [Source](#) — Information, assistance, counseling, support groups, training, respite, and supplemental services.
- [11] **University of Hawai'i.** *Alzheimer's Disease Research Center Report to the 2026 Hawai'i Legislature.* 2026. [Source](#) — Dementia trends, Native Hawaiian and Pacific Islander disparities, workforce, research, and neighbor-island access.
- [12] **Executive Office on Aging and University of Hawai'i Center on Aging.** *Strengthening Hawai'i's Long-Term Direct Care Workforce.* 2025. [Source](#) — Critical direct-care workforce shortage and recruitment/retention challenges.
- [13] **Hawai'i Department of Health.** *Executive Office on Aging Elder Programs Annual Report to the 2026 Legislature.* 2025. [Source](#) — CMS GUIDE participation at Straub Benioff Medical Center and statewide dementia activities.
- [14] **Alzheimer's Impact Movement.** *The Alzheimer's Screening and Prevention (ASAP) Act.* Accessed July 24, 2026. [Source](#) — H.R. 6130/S. 3267; proposed Medicare pathway for blood-based Alzheimer's screening.
- [15] **U.S. Government Publishing Office.** *H.R. 3747, Accelerating Access to Dementia and Alzheimer's Provider Training Act.* July 20, 2026. [Source](#) — Engrossed House bill; Project ECHO reauthorization and dementia training grants.
- [16] **Office of U.S. Representative Troy Balderson.** *House Passes the AADAPT Act to Improve Early Alzheimer's Detection and Care.* July 20, 2026. [Source](#) — House passage and intended provider-training effects.

Source-integrity note

The “today” and “per day” figures are explicitly labeled planning estimates because the cited sources do not provide a live Hawai'i dementia registry. The report preserves the published 31,200 benchmark, shows the assumptions used to update it, and presents uncertainty ranges instead of asserting false precision.