

MEMORY ACROSS THE MARIANAS

Alzheimer’s disease and all dementias in Guam, Saipan and Tinian

Population, caregiving, clinical capacity and policy outlook | 2000–2050

GUAM	SAIPAN	TINIAN
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THE OPERATING PREMISE

Memory care should be island-close, family-supported and specialist-connected—even when the specialist, scan or treatment must cross water.

Prepared for Jerry Perone | August 2026

Research report • evidence review • demographic scenario • service-capacity analysis

A clear line between what is known and what is modeled

No representative, island-specific clinical prevalence survey or complete diagnosed-case registry was located for Guam, Saipan or Tinian. The report therefore keeps four evidence types visibly separate:

TYPE	LABEL	WHAT IT MEANS
A	Observed	Counts or percentages measured by the Census, a named survey or a public program record. These are not forecasts.
B	Published local signal	A local study, registry query or service record. It may describe access or a sample; it is not automatically population prevalence.
C	Planning benchmark	An age-structure model built for this report. It estimates need if 2026 U.S. age-specific Alzheimer's rates apply and Alzheimer's represents 60%–70% of dementia.
D	Projection / scenario	A future trajectory. Guam uses UN WPP directly; Saipan and Tinian apply CNMI-wide UN growth factors to their 2020 age bands. Migration and shocks can change it.

THE SINGLE MOST IMPORTANT CAVEAT

The 2026 and future dementia figures are planning benchmarks—not a count of people already diagnosed. A positive screen, claims record, diagnosis, provider listing and demographic model are never treated as interchangeable.

Geography note. Guam is a separate U.S. territory. Saipan and Tinian are islands within the Commonwealth of the Northern Mariana Islands (CNMI). CNMI-wide evidence is labeled as such; it is not silently reassigned to one island. Combined totals cover only the three named islands and exclude Rota and the Northern Islands.

SOURCE / Census Island Areas data [1–8]; UN WPP 2024 [9]; Alzheimer's Association [10]; WHO [11].

READING MAP

What each section answers

SECTION	THEME	QUESTION ANSWERED
01	Executive finding	What decision-makers need to know now
02	The demographic turn	How population contraction and longevity alter demand
03	How many people?	What the age-profile benchmark says—and does not say
04	Care in the household	Why families are the operating center of long-term care
05	Risk and measurement	Which preventable risks are visible and where data are missing
06	Services and diagnosis	What each island can do locally and what must travel
07	2030 and 2050	What the trajectory means for workforce, transport and families
08	A practical response	How a Marianas Memory Network could operate
09	Methods and sources	Assumptions, limitations and evidence links

Language safeguards

- Dementia is an umbrella syndrome involving decline in memory, thinking, behavior or function. Alzheimer's disease is the most common cause, but vascular, Lewy body, frontotemporal and mixed dementias also matter.[11]
- A memory complaint or positive screen calls for assessment; it is not a diagnosis.
- A missing public provider record means access was not verified. It does not prove that no visiting, informal or unlisted service exists.
- 'Family caregiver' includes spouses, adult children, siblings, extended family and other trusted people. The report does not assume one household structure or one preferred language.

CLINICAL SAFETY

Sudden confusion, new weakness, severe headache, loss of consciousness or abrupt behavior change may be a medical emergency. Do not assume that an acute change is dementia.

01 / EXECUTIVE FINDING

The islands already carry a dementia burden; the pathway is fragmented

Aging is accelerating while specialist access, transport and routine dementia measurement remain uneven.

~4,294 2026 midpoint Across the three islands; modeled, not diagnosed	~10,493 2050 midpoint About 2.4× the 2026 planning benchmark	2 systems Governance reality Guam and CNMI require separate accountable leads
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The estimated burden is concentrated on Guam in absolute numbers, but the operating challenge is not proportional to population. Saipan faces a steep late-life aging scenario; Tinian's small denominator means a handful of high-need cases can consume scarce transport, clinic and caregiver capacity. In all three places, the practical unit of care is the person plus the family member who helps them function.

ISLAND	2026 RANGE	2026 MID	2050 MID	CHANGE
Guam	3,475–4,054	3,742	8,359	2.2×
Saipan	492–574	530	2,069	3.9×
Tinian	21–24	22	65	2.9×

THREE TRUTHS

1) Family care is already the long-term-care system. 2) Primary care must be the front door because specialty access is uneven. 3) Data collection and care redesign can begin before a perfect prevalence survey exists.

SOURCE / Planning benchmark built from Census/UN age structure [1–10] and WHO Alzheimer share [11].

01A / THE DECISION AGENDA

Six actions that do not require waiting for perfect prevalence data

	ACTION	OPERATING DEFINITION
1	Name two accountable leads	One in Guam and one in CNMI, with responsibility for the pathway, data set and annual public report.
2	Make recognition routine	Train primary care, senior programs, pharmacies and faith/community partners to identify change and route concerns.
3	Standardize the first work-up	Preferred-language history, informant interview, functional assessment, medication review, labs, mood/hearing checks and imaging criteria.
4	Schedule specialist reach	Regular tele-neurology/geriatrics case review, periodic visiting clinics and documented off-island escalation.
5	Treat caregiver capacity	Name the caregiver, measure strain, teach skills and connect respite, meals, transport, benefits and safety support.
6	Publish a minimum data set	Concerns received, wait time, assessment completion, diagnosis, safety plan, caregiver outcome and referral completion.

A proposed 2030 service promise

5 days Navigator contact From receipt of a memory concern	30 days Primary-care memory visit Unless urgency requires faster care
100% Named caregiver/contact With consent and preferred language	1 / year Public dashboard Waits, completion, safety and caregiver outcomes

These are proposed performance targets, not claims about current wait times or service levels.

01B / GOVERNANCE

Three islands, two public systems, one shared learning agenda

Guam and the CNMI do not share one Medicaid program, health department, hospital authority or aging-services administration. A regional initiative should therefore connect two accountable systems rather than blur them.

PLACE	PUBLIC ANCHOR	PRACTICAL ROLE	ACCOUNTABILITY
Guam	Guam DPHSS; Guam hospitals and clinics	Local assessment and imaging; dementia-specific support assets; off-island escalation when needed	Guam dementia lead
Saipan	CNMI CHCC; CNMI Office on Aging	CNMI memory hub; primary/specialty work-up; tele-consult; referral coordination	CNMI dementia lead
Tinian	CHCC Tinian Health Center; CNMI Office on Aging	Island spoke; recognition, basic work-up, tele-consult, transport and follow-up	CNMI lead with named Tinian coordinator

WHAT CAN BE SHARED

Training, common forms, a minimum data set, specialist case conferences, caregiver curriculum, quality measures and referral agreements can be shared without pretending that funding and statutory authority are shared.

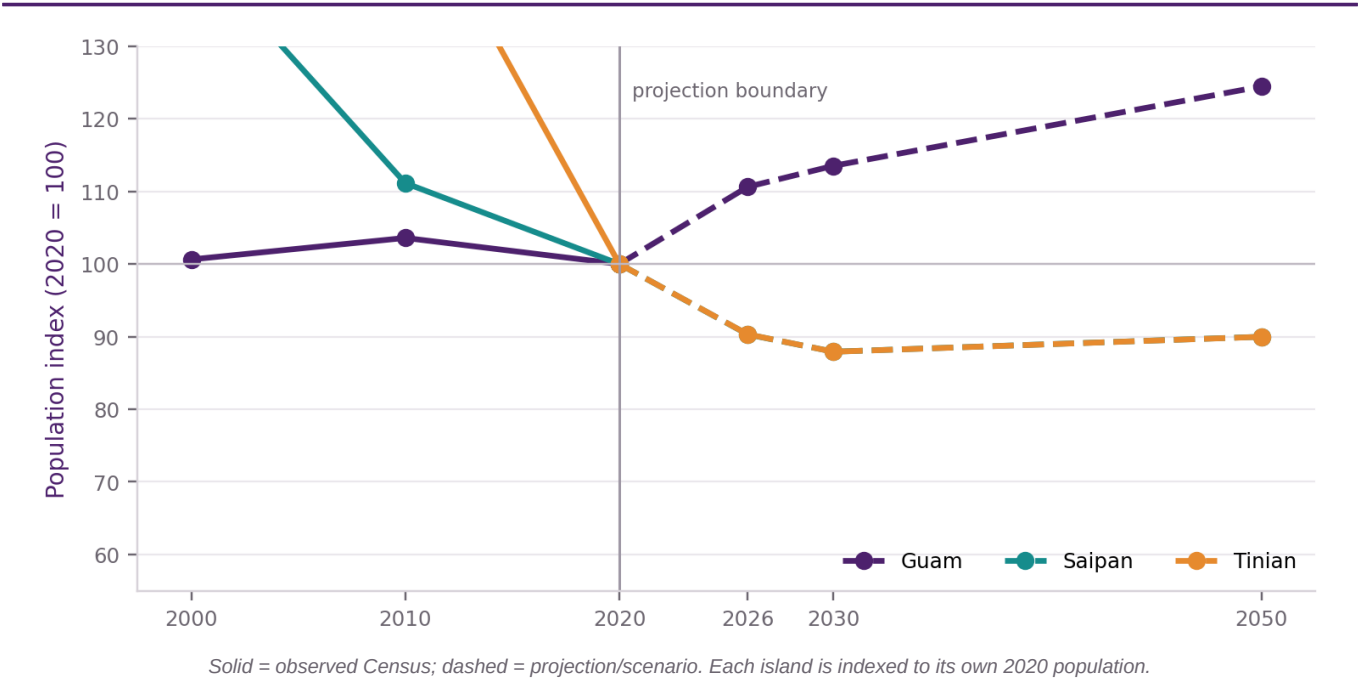
WHAT MUST REMAIN LOCAL

Budget authority, workforce contracts, privacy governance, Medicaid operations, transport purchasing, hospital credentialing and accountability for actual wait times.

SOURCE / Guam DPHSS [21]; CHCC [32]; CNMI Office on Aging [28]; CMS CNMI SPA [33].

The population path and the aging path are not the same

A flat or shrinking total population can still produce a rapid increase in late-life care demand.



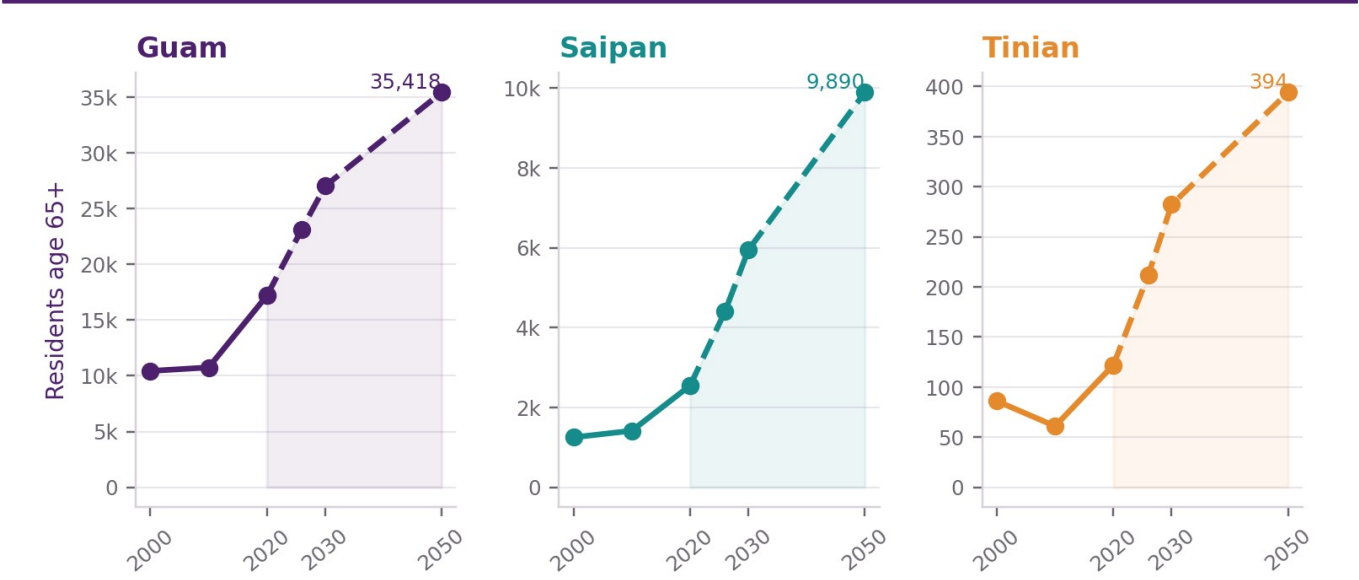
ISLAND	2000 OBS.	2020 OBS.	2026 PROJ.	2050 PROJ.
Guam	154,805	153,836	170,189	191,460
Saipan	62,392	43,385	39,173	39,038
Tinian	3,540	2,044	1,846	1,839

READ THE SEAM

The UN series and the decennial Census have different bases. The 2020-to-2026 break—especially on Guam—should not be read as a measured six-year surge. It is a model boundary. Future comparisons are planning scenarios.

SOURCE / Census 2000/2010/2020 [1–8]; UN WPP 2024 medium variant [9].

The late-life population grows faster than the population as a whole



Observed through 2020; projected/scenario values after 2020.

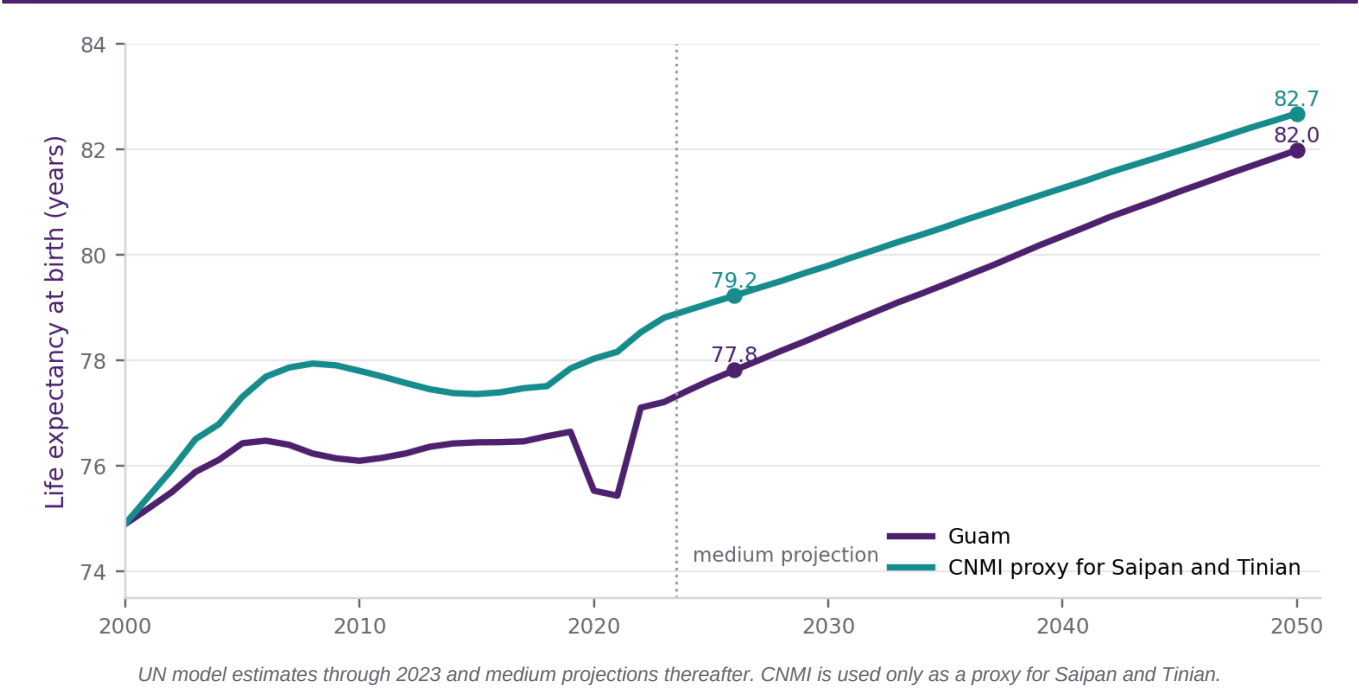
ISLAND	2020 OBSERVED	2026 SCENARIO	2050 SCENARIO
Guam	17,190 (11.2%)	23,137 (13.6%)	35,418 (18.5%)
Saipan	2,548 (5.9%)	4,407 (11.3%)	9,890 (25.3%)
Tinian	122 (6.0%)	212 (11.5%)	394 (21.4%)

The most operationally important shift is within the older population. The 85+ group—where age-specific Alzheimer’s prevalence is highest—expands from 1,217 people on Guam in the 2020 Census to 8,148 in the 2050 UN scenario. Saipan’s 85+ scenario rises from 107 to 1,515; Tinian’s from two to 28. The small-island values are particularly sensitive to migration and rounding.[1–10]

WHY THIS MATTERS

Planning on the number of older adults alone understates complexity. Later-life cohorts generate more need for hands-on care, medication supervision, falls prevention, decision support and transport—even if the total population changes little.

Longer lives create an opportunity—and a longer window of risk



77.8 Guam, 2026 Years at birth; UN medium variant	79.2 CNMI, 2026 Proxy for Saipan and Tinian	82.0 / 82.7 2050 scenarios Guam / CNMI, respectively
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Life expectancy is not healthy life expectancy, and a territory-wide modeled average cannot describe one island, village or family. Its planning value is directional: more people can survive into the ages where dementia, multimorbidity and caregiving dependence become more common.

THE PREVENTION OPPORTUNITY

Longer life does not make dementia inevitable. WHO’s 2026 guidance identifies modifiable risks across the life course, including blood pressure, tobacco, physical inactivity, diabetes, hearing loss, depression, social isolation and other factors.[12]

SOURCE / UN WPP 2024 [9]; WHO dementia risk-reduction guidance [12].

The benchmark is simple enough to audit

For each island and year, the report places residents into three older-age bands, applies the 2026 U.S. clinical Alzheimer’s prevalence for that band, and converts Alzheimer’s to a range for all dementias.

AGE BAND	ALZHEIMER’S RATE	CALCULATION
65–74	5.2%	Age-band residents × 0.052
75–84	13.8%	Age-band residents × 0.138
85+	35.8%	Age-band residents × 0.358

All dementia = Alzheimer’s estimate ÷ 0.70 to ÷ 0.60 | midpoint = ÷ 0.65

INTERPRETATION

The range reflects uncertainty in Alzheimer’s share of dementia; it is not a statistical confidence interval. Holding prevalence rates constant isolates the demographic effect. Younger-onset cases are excluded.

WHAT THE MODEL DOES NOT KNOW

Local cardiovascular risk, education, language, survival, diagnosis practices, genetics, migration, disaster exposure, prevention and treatment. It should size a pathway, not label an individual or replace local measurement.

SOURCE / Age-specific rates: 2026 Alzheimer’s Facts and Figures [10]. Alzheimer share: WHO [11].

Guam carries the largest absolute burden—and the strongest local platform to organize it

2,432 Alzheimer's, 2026 Age-only planning estimate	3,742 All dementias, 2026 Range 3,475–4,054	8,359 All dementias, 2050 Range 7,762–9,055
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YEAR	65–74	75–84	85+	ALZ.	ALL DEMENTIA
2000 observed	5,973	3,845	616	1,062	1,517–1,770
2010 observed	6,919	3,135	693	1,041	1,486–1,734
2020 observed	11,571	4,402	1,217	1,645	2,350–2,741
2026 scenario	14,128	6,944	2,065	2,432	3,475–4,054
2030 scenario	15,573	8,750	2,693	2,981	4,259–4,969
2050 scenario	14,502	12,768	8,148	5,433	7,762–9,055

The midpoint rises from about 2,531 in the 2020 observed age structure to 3,742 in the 2026 UN scenario and 8,359 in 2050. By 2050, more than half of the modeled Alzheimer's total is generated by the 85+ band. The immediate issue is not whether dementia exists; it is whether people move reliably from concern to assessment, diagnosis, care planning and caregiver support.

PLANNING CAUTION

The 2026 UN population base differs from the 2020 Census base. Treat the trend as a capacity scenario, not a measured post-2020 case surge. No complete Guam diagnosis registry was located.

SOURCE / Census/UN age structure [1–10]; WHO Alzheimer share [11]. Counts rounded.

Saipan’s scenario is a steep aging story inside a smaller population

345 Alzheimer’s, 2026 Age-only planning estimate	530 All dementias, 2026 Range 492–574	2,069 All dementias, 2050 Range 1,921–2,241
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YEAR	65–74	75–84	85+	ALZ.	ALL DEMENTIA
2000 observed	837	349	65	115	164–192
2010 observed	1,037	332	47	117	167–194
2020 observed	1,992	449	107	204	291–340
2026 scenario	3,421	847	139	345	492–574
2030 scenario	4,418	1,354	173	479	684–798
2050 scenario	4,108	4,267	1,515	1,345	1,921–2,241

The midpoint moves from about 314 in the 2020 observed age structure to 530 in 2026, 736 in 2030 and 2,069 in 2050. The late acceleration is driven by the CNMI scenario's growth in ages 75–84 and 85+, not by total-population growth. Saipan therefore needs a durable pathway that can scale in complexity even if total population remains near today's level.

PLANNING CAUTION

Saipan does not have a standalone official population projection. The report applies CNMI-wide age-band growth factors to Saipan's 2020 Census profile. Migration, disaster recovery and labor flows can materially alter the result.

SOURCE / Census/UN age structure [1–10]; WHO Alzheimer share [11]. Counts rounded.

Small numbers do not mean a small operating problem

15 Alzheimer's, 2026 Age-only planning estimate	22 All dementias, 2026 Range 21–24	65 All dementias, 2050 Range 60–70
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YEAR	65–74	75–84	85+	ALZ.	ALL DEMENTIA
2000 observed	51	31	4	8	12–14
2010 observed	44	12	5	6	8–10
2020 observed	104	16	2	8	12–14
2026 scenario	179	30	3	15	21–24
2030 scenario	231	48	3	20	28–33
2050 scenario	214	152	28	42	60–70

The midpoint is about 22 people in 2026, rising to 30 in 2030 and 65 in 2050. Those counts are modest beside Guam and Saipan, but Tinian's health center, transport options and caregiver pool are also small. One person needing repeated appointments, behavioral support, overnight supervision or off-island imaging can create a disproportionate burden for a family and the island's service network.

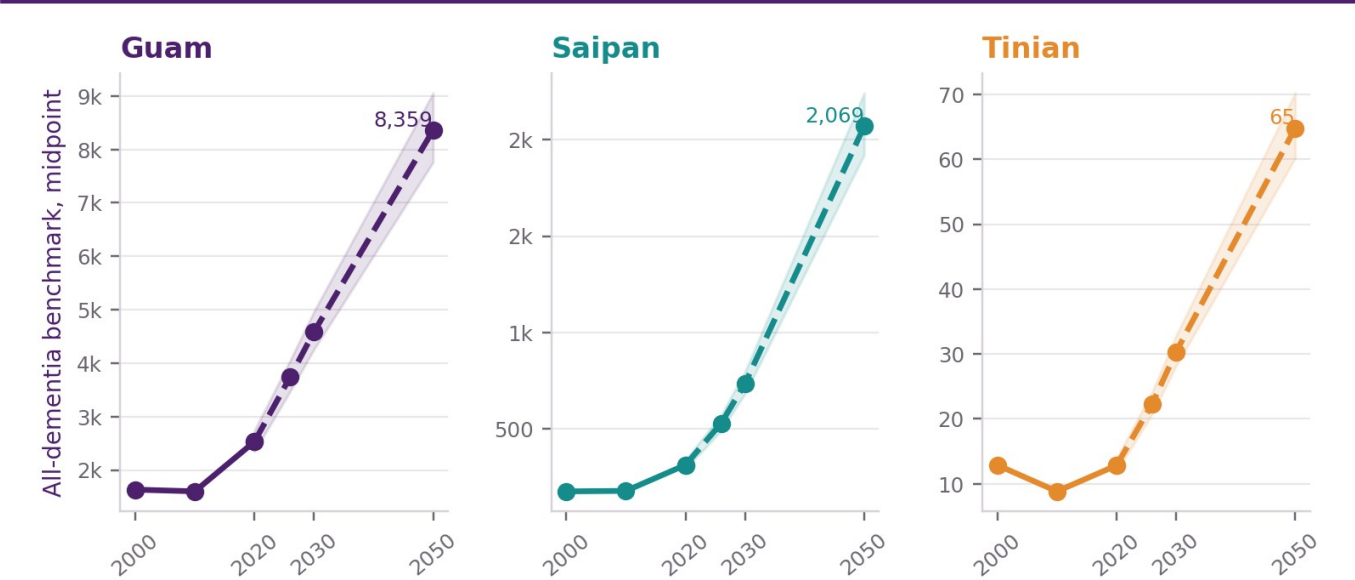
PLANNING CAUTION

Tinian's very small age bands make the benchmark highly round-sensitive. The 2020 Census counted only two residents age 85+. This page is for redundancy and referral planning—not precise forecasting.

SOURCE / Census/UN age structure [1–10]; WHO Alzheimer share [11]. Counts rounded.

03D / THE THREE-ISLAND VIEW

The same condition creates three different operating problems



All-dementia midpoint. Shaded projection band reflects Alzheimer's as 60%–70% of dementia, not statistical uncertainty.

ISLAND	PLANNING LOGIC	SYSTEM RESPONSE
Guam	Scale	Build an end-to-end pathway across multiple hospitals, clinics, imaging and support assets.
Saipan	Growth in complexity	Create the CNMI hub, specialist reach and off-island completion tracking before the 75+ wave peaks.
Tinian	Redundancy	Guarantee a local front door, tele-consult, transport backup and continuity when one person or vehicle is unavailable.

DO NOT ALLOCATE EFFORT BY CASE COUNT ALONE
A hub needs scale; a spoke needs reliability. A per-capita formula can underfund Tinian's fixed costs for training, coordination and transport while overlooking Guam's need for high-volume navigation.

03E / WHAT DRIVES THE CURVE

The 85+ population changes the clinical and caregiving mix

ISLAND	85+ IN 2026	85+ IN 2050	SHARE OF ALZ. 2026	SHARE OF ALZ. 2050
Guam	2,065 / 8.9%	8,148 / 23.0%	30.4%	53.7%
Saipan	139 / 3.2%	1,515 / 15.3%	14.4%	40.3%
Tinian	3 / 1.4%	28 / 7.1%	7.4%	23.8%

Age structure changes what a system must be ready to do. Later-stage dementia is not confined to the oldest adults, but a larger 85+ population generally raises the frequency of frailty, falls, sensory loss, polypharmacy, functional dependence and caregiver intensity.

CLINICAL IMPLICATION

The pathway cannot end at a diagnosis. It needs medication review, driving and wandering safety, advance-care conversations, caregiver training, crisis prevention, home supports and palliative approaches as needs change.

MEASUREMENT IMPLICATION

Track stage and function, not just diagnosis. Two islands with the same dementia count can have very different needs if one has more people with severe impairment, living alone or requiring off-island care.

The person and the caregiver are one care unit

15.3% Guam households Multigenerational, 2020 Census	13.0% CNMI households Multigenerational, 2020 Census	57% / 74% Non-English at home Guam / CNMI, 2020 Census
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A Guam study describes most people with Alzheimer’s disease and related dementias as living at home with family, consistent with CHamoru obligations to care for manåmko’. It also reports limited residential capacity and underused community resources because awareness and access are uneven.[16] The same family-centered logic is visible in CNMI aging plans, but no representative caregiver time-use survey for Saipan or Tinian was located.[28,29]

WHAT FAMILIES OFTEN DO	WHAT THE SYSTEM SHOULD SUPPLY
Notice change, supervise medicines, meals and money	A named navigator and a written plan in the preferred language
Provide transport and accompany visits	Coordinated scheduling, travel support and telehealth where clinically appropriate
Manage behavior, sleep, wandering and personal care	Skills training, respite, crisis plan and home-safety support
Make decisions as capacity changes	Advance-care planning, legal/benefit navigation and supported decision-making

DO NOT MISTAKE CO-RESIDENCE FOR CAPACITY
A household can be multigenerational and still lack time, money, sleep, transport, clinical guidance or a substitute caregiver. Family commitment is an asset; it is not a financing mechanism.

SOURCE / Census household and language profiles [1,2,39]; Guam dementia-resource study [16]; CNMI Office on Aging [28,29].

Every memory pathway should leave the caregiver stronger

MOMENT	MINIMUM CAREGIVER PRACTICE
At first concern	Record who helps, preferred language, hearing/vision needs, specific changes and immediate safety risks.
At assessment	Invite an informant with consent; screen caregiver strain; explain uncertainty and next steps.
At diagnosis	Give a written plan, medication list, emergency guidance, benefits/support referrals and a follow-up date.
Every follow-up	Reassess function, falls, wandering, driving, sleep, nutrition, caregiver strain and whether referrals were completed.
During crisis	Use a shared plan that distinguishes medical emergency, behavioral escalation and caregiver exhaustion.

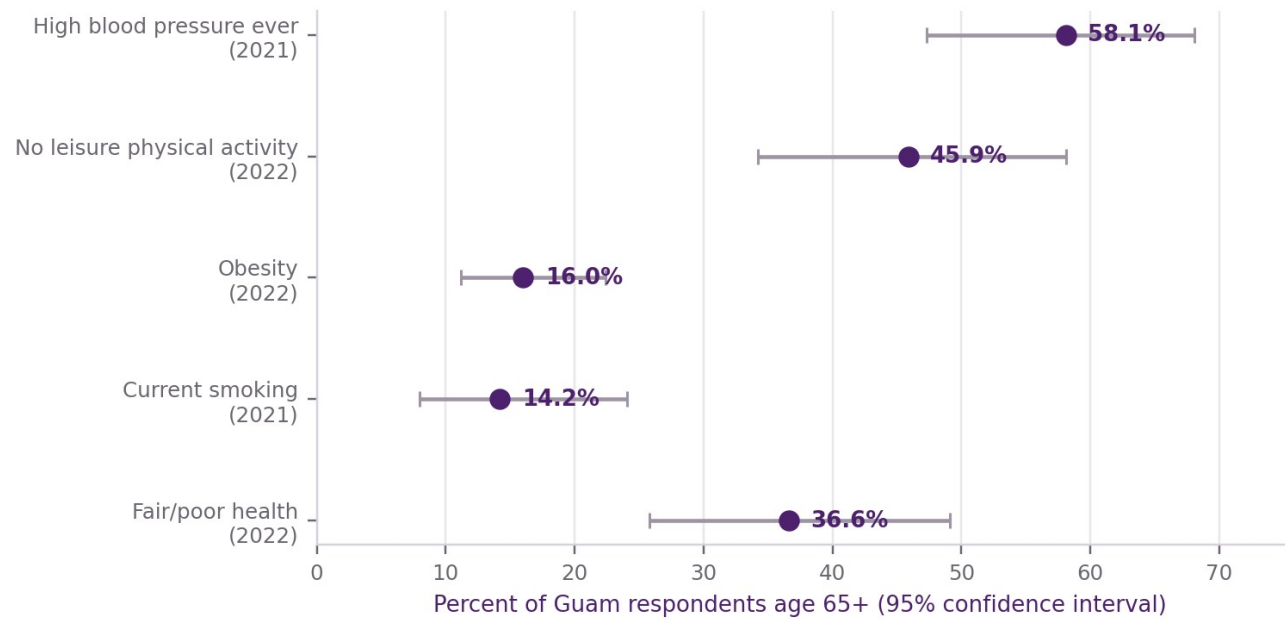
A practical caregiver outcome set

- Caregiver knows who to call and what happens next.
- Caregiver can name two safety priorities and demonstrate key care skills.
- Caregiver strain is measured with a brief repeatable tool, not inferred from appearance.
- A backup caregiver or contingency plan is documented where possible.
- Respite, food, transport and benefits referrals are tracked to completion—not merely handed out.

BUILD ON WHAT EXISTS

Guam has dementia-specific telehealth support and training through the University of Guam. CNMI Office on Aging lists caregiver-support, meals, transport and senior-center services. A network should strengthen these assets and close handoff gaps, not duplicate them.[17–19,28]

The best dementia strategy begins years before a diagnosis



Latest Guam BRFSS estimates available in the CDC Healthy Aging data for respondents age 65+. Years vary; intervals are wide.

Guam’s survey signals show substantial burdens relevant to brain health, especially hypertension and physical inactivity. They should guide prevention partnerships, not be converted into dementia prevalence. No comparable public CNMI Healthy Aging series was located, and CDC cognitive-health/caregiving indicator shells for Guam did not contain reportable values in the downloaded records.[14,15]

PREVENTION LEVER	MEMORY-PATHWAY ACTION
Blood pressure / diabetes	Make control visible in every memory-risk and follow-up plan.
Physical activity	Link safe, culturally acceptable activity to senior centers and primary care.
Hearing / vision	Check devices and access before cognitive testing; refer for correction.
Tobacco / alcohol	Offer brief intervention and treatment; avoid stigma.
Depression / isolation	Screen, treat and connect people to meaningful social participation.

SOURCE / CDC Healthy Aging and Cognitive Health data [14,15]; WHO 2026 guidance [12]; CDC Pacific Islands Road Map [13].

05A / THE DATA GAP

If the system cannot count the pathway, it cannot improve it

The most useful first data system is not an expensive prevalence registry. It is a small operational record that follows each concern from recognition to outcome.

DOMAIN	MINIMUM FIELDS
Reach	Memory concerns received; source; island; preferred language; age band
Access	Days to navigator contact; days to primary-care memory visit; no-show/cancellation
Assessment	Informant present; function; depression; hearing/vision; labs; imaging indication/completion
Outcome	Diagnosis category; uncertainty; severity; safety plan; caregiver identified
Support	Education; respite/meal/transport/benefit referrals; completion within 30/90 days
Escalation	Tele-specialist review; visiting clinic; off-island referral; completion and elapsed days

PRIVACY AND SOVEREIGNTY

Use the minimum necessary information, define Guam and CNMI data stewards separately, obtain appropriate consent, and publish aggregated measures. Tinian's small counts require suppression rules to prevent accidental identification.

THE FIRST PUBLIC QUESTION

How many people completed the pathway within the proposed time standard—and where did they stall? That answer is more actionable than a single prevalence number.

A memory concern needs one visible route through the system

	STEP	WHAT HAPPENS	MINIMUM STANDARD
1	RECOGNIZE	Person, family, senior program, pharmacy or clinician notices change	Same day if acute; otherwise route to navigator
2	ASSESS	Preferred-language history + informant + function + medication/mood/sensory review	Primary care; basic labs; imaging criteria
3	CLARIFY	Dementia, mild cognitive impairment, delirium, depression or another cause	Tele/visiting specialist or off-island review when needed
4	PLAN	Diagnosis disclosure, safety, medicines, advance planning and caregiver education	One written plan and named next contact
5	SUPPORT	Meals, transport, benefits, respite, training and social connection	Closed-loop referrals; confirm receipt
6	FOLLOW	Function, safety, caregiver strain and treatment response	Scheduled follow-up; re-escalate when needs change

THE PATHWAY IS DIAGNOSIS-AGNOSTIC

It should help a person whether the final answer is Alzheimer’s, vascular or mixed dementia, another neurodegenerative disorder, depression, delirium, medication effect, hearing loss or no dementia. A good pathway also identifies reversible and urgent problems.

THE HANDOFF RULE

The referring service remains responsible until the receiving service accepts the referral, the person/family knows the plan, and transport or telehealth arrangements are confirmed.

SOURCE / Pathway synthesis informed by local service sources [16–35] and dementia-care design reference [40].

06A / GUAM

Guam has pieces of a memory system—but not a verified end-to-end pathway

CAPABILITY	PUBLIC SIGNAL	INTERPRETATION
Primary care / hospitals	Present	Multiple clinical entry points; HRSA still designates shortage areas.
CT / MRI	Publicly documented	GRMC lists CT and MRI; local protocol and access times require verification.
Neurology	Thin registry signal	Two Guam-location individual NPPES neurology records found; listing ≠ appointments.
Dementia support	Documented	UOG telehealth support, caregiver groups and training; Alzheimer's Association Hawai'i serves Guam.
Day support	Historical documentation	A 2020 legislative record describes Guma Ginefli'e Dementia Day Care; current capacity should be verified.
Residential dementia care	Published gap	A 2025 Guam paper reported no nursing/assisted-living setting specializing in ADRD.
Amyloid therapy readiness	Not established by public scan	MRI exists, but amyloid confirmation, infusion capacity, counseling, drug access and monitoring protocol require audit.

GUAM'S FIRST DESIGN TASK

Connect existing assets with one referral form, one navigator function and one measurable pathway. The gap appears organizational as well as clinical.

Provider-directory counts are deliberately conservative and time-stamped. Records may be old, clinicians may practice under broader taxonomies, and visiting services may not appear. Local verification should precede public claims or referral instructions.

SOURCE / Guam study [16]; UOG [17–19]; DPHSS [21,22]; GRMC [23]; NPPES [25]; HRSA [26,27].

Saipan must become the CNMI memory hub

ASSET / GAP	PUBLICLY DOCUMENTED SIGNAL
CHCC	Sole CNMI hospital/public-health/behavioral-health corporation; principal island clinical anchor.
Radiology	CHCC publicly lists CT, ultrasound, mammography and fluoroscopy. MRI or PET was not listed on the reviewed page.
Senior supports	CNMI Office on Aging lists meals, transport, health screenings and caregiver-support functions through Man Amko' centers.
Specialists	No CNMI-location individual NPPES neurology or geriatric-medicine records were found in the reviewed taxonomy searches.
Off-island care	Medicaid SPA and federal reviews document the need for off-island transportation/referrals when specialty care is unavailable locally.
Shortage signal	HRSA designates CNMI primary-care and mental-health shortage areas; designation figures are planning signals, not current staffing censuses.

SAIPAN'S MINIMUM HUB FUNCTION

A trained memory team does not require a resident dementia subspecialist. It does require a consistent first work-up, scheduled specialist review, a named navigator, access to CT/labs, caregiver support and completion tracking for off-island escalation.

DO NOT DESIGN AROUND A ONE-TIME VISITOR

Visiting specialty clinics add value, but continuity must live in CHCC and Office on Aging workflows so the pathway survives turnover, travel disruption and grant cycles.

SOURCE / CHCC [31,32]; CNMI Office on Aging [28,29]; CMS [33]; GAO [24,34,35]; NPPES/HRSA [25–27].

Tinian needs a guaranteed spoke, not a miniature specialty center

1 Island medical facility Tinian Health Center, per CHCC	24 / 7 Emergency service With weekday primary care	~22 2026 dementia midpoint Small-number planning scenario
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LAYER	TINIAN OPERATING STANDARD
Do locally	Recognize concern; assess function and safety; medication/mood/sensory review; basic labs; caregiver plan; tele-visit setup.
Connect to Saipan	CT or additional testing; memory-team review; visiting clinic; higher-complexity medical and behavioral evaluation.
Escalate off island	Specialty diagnostics or treatment unavailable in CNMI, using explicit authorization, travel and follow-up protocols.
Protect continuity	One named island coordinator; backup contact; medication reconciliation after every transfer; plan for weather/flight disruption.

THE FIXED-COST PRINCIPLE

Tinian needs training, telehealth equipment, privacy, coordination time and transport readiness even when monthly referrals are few. Those are fixed capabilities; a simple case-volume budget will underprovide them.

CHCC describes Tinian Health Center as the island's only medical facility, with primary care, 24/7 emergency service, telehealth and inter-island referral. CNMI Office on Aging lists island senior-center, meal and transport functions. Current staffing and appointment availability should be verified locally.[28,30]

SOURCE / Tinian Health Center [30]; CNMI Office on Aging [28]; CMS off-island transportation SPA [33].

The scarce resource is not only a specialist—it is coordinated clinical time

PLACE	NPPES NEUROLOGY	NPPES GERIATRIC SIGNAL	HRSA SHORTAGE SIGNAL
Guam	2 individual neurology records	Up to 4 Guam-location individual records with a geriatric taxonomy signal	Primary-care HPSA and low-income mental-health HPSA designations
CNMI	0 individual neurology records	0 individual geriatric-medicine records	Geographic primary-care and mental-health HPSA designations

NPPES is a registration system, not a live access directory. A record can be active while its location, taxonomy or availability is stale. HRSA designation denominators can differ from Census or UN totals. These sources show workforce fragility; they do not count appointments or prove absence.[25–27]

A workforce design that fits the islands

- Train a small core memory team in Guam and Saipan: physician/advanced-practice clinician, nurse/care manager, social-work/navigation and behavioral-health capability.
- Give Tinian named primary-care and aging-services coordinators with protected tele-consult time and backup coverage.
- Contract recurring tele-neurology/geriatrics case conferences rather than ad hoc advice.
- Create competency-based training for community health workers, senior-center staff, home-care workers, emergency teams and family caregivers.
- Measure turnover, vacancy time, available visit slots and completed consults—not just funded positions.

RETENTION IS A CARE-QUALITY STRATEGY

Federal reviews describe persistent recruitment and referral challenges across the Pacific territories. A pathway that depends on one clinician is a risk; teams, protocols and shared records create resilience.[24,34,35]

Lytico-bodig belongs in Guam’s history—but not inside today’s Alzheimer’s count

Guam is internationally known for the historical cluster of amyotrophic lateral sclerosis and parkinsonism–dementia complex (ALS/PDC), often called lytico-bodig. It is a distinct neurodegenerative complex with motor, parkinsonian and cognitive features—not a synonym for Alzheimer’s disease.[37,38]

Distinct Clinical history Do not relabel ALS/PDC as Alzheimer’s	Declined Population signal Incidence/prevalence fell dramatically	Unresolved Etiology Do not present one causal theory as settled
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SAFE STATEMENT	UNSAFE INFERENCE
Guam has an important historical ALS/PDC experience.	Historic ALS/PDC incidence equals current dementia prevalence.
The complex has declined substantially, and etiology remains debated.	One food, toxin or gene is proven to explain all cases.
Current memory services should recognize diverse neurodegenerative conditions.	Every Guam memory complaint should be framed as lytico-bodig.
Research history may support local trust and scientific partnership.	Historic research substitutes for a current ADRD registry or care pathway.

MODEL BOUNDARY

This report’s Alzheimer’s/all-dementia benchmark does not add a separate ALS/PDC case estimate. Doing so would risk double counting and mix a historical disease complex with a demographic planning model.

SOURCE / Peer-reviewed reviews of Guam ALS/PDC [37,38].

Build the foundation before promising disease-modifying therapy

LAYER	REQUIREMENT	PLACEMENT
1. Core pathway	History, informant, function, medication/mood/sensory review, labs, safety, caregiver plan	All three islands
2. Structural imaging	CT or MRI when clinically indicated; image transfer and interpretation	Guam/Saipan hubs; Tinian referral
3. Etiology clarification	Specialist review; biomarker strategy when results would change care	Scheduled regional/off-island access
4. Anti-amyloid readiness	Confirmed amyloid, eligibility/counseling, infusion operations, serial MRI, ARIA response and reliable follow-up	Feasibility audit before offering

FDA labeling for donanemab requires confirmation of amyloid pathology, intravenous dosing and scheduled MRI monitoring, with additional clinical capacity to detect and manage amyloid-related imaging abnormalities. MRI hardware alone is not readiness.[36]

NEAR-TERM PRIORITY

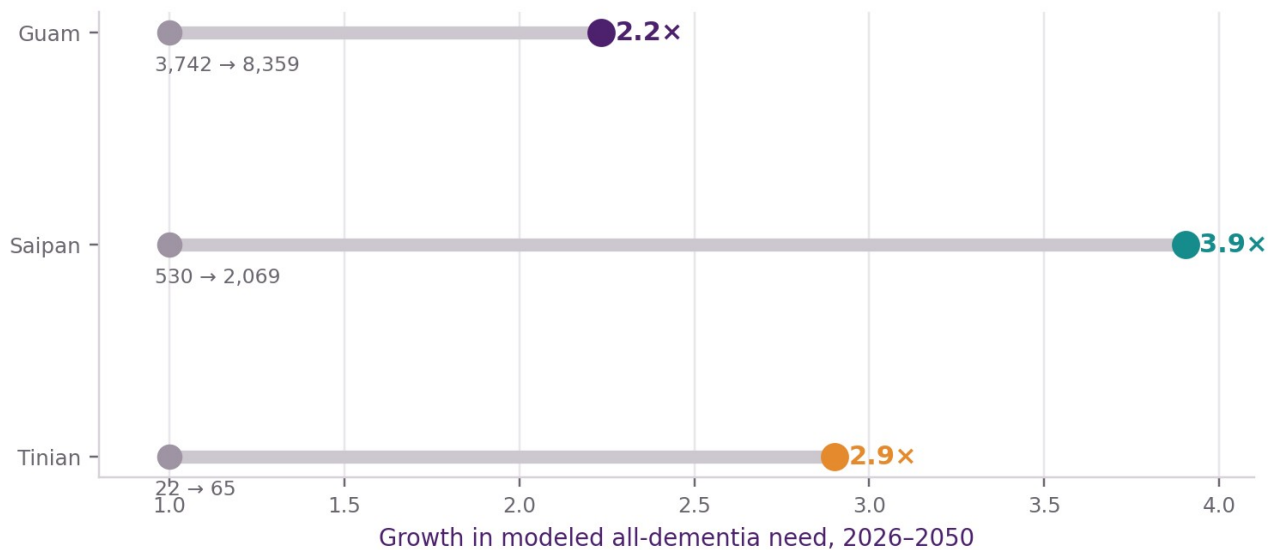
For Saipan and Tinian, the first investment should be reliable recognition, reversible-cause assessment, safety, caregiver support and referral completion. Guam can conduct a formal readiness audit without making availability claims before financing, staffing and protocols are verified.

EQUITY TEST

A treatment pathway is not equitable if serial scans, infusion visits, emergency response or follow-up depend on travel that families cannot reliably complete.

SOURCE / FDA prescribing information [36]; local imaging/service sources [23,30–33].

Demand grows by more than case count



Midpoint planning benchmark. Values shown inside the chart are 2026 → 2050 counts.

ISLAND	CAPACITY THAT MUST GROW
Guam	High-volume navigation, primary-care memory slots, MRI/consult scheduling, caregiver programs and crisis alternatives.
Saipan	Larger 75+ cohort, more complex home care, recurring specialist sessions and stronger off-island coordination.
Tinian	Reliable telehealth, transport redundancy, respite options and continuity through flight/weather disruption.

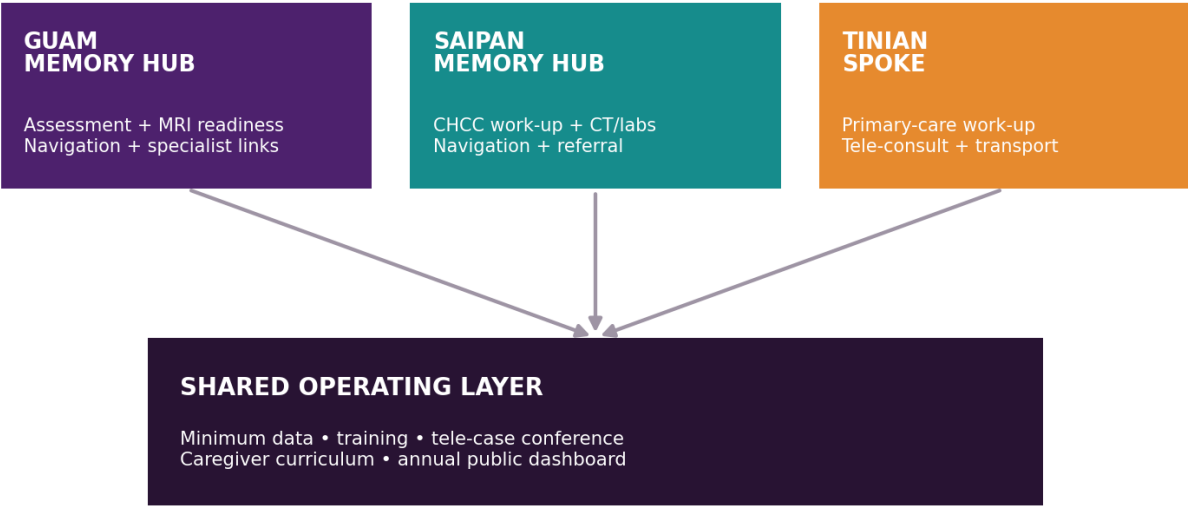
Case growth multiplies several workloads: visits, informant interviews, labs and scans, benefits applications, caregiver education, safety plans, crisis contacts and follow-up. The workload may increase faster than prevalence when people live longer with greater functional dependence.

2050 IS A STRESS TEST, NOT A PROMISE

The scenario should prompt no-regret investments—data, workforce, navigation, caregiver capacity and transport—not a claim that exact future counts are known.

SOURCE / Report planning benchmark; Census/UN age structure [1–10].

A Marianas Memory Network: local front doors, shared operating standards



Proposed operating model. Guam and CNMI retain separate governance, funding and accountability.

The model adapts the nearby Hawai'i Memory Network concept—regional specialists, memory hubs, navigation and community-to-primary-care connection—to the Marianas' different geography and governance. It is a design proposal, not evidence that a Marianas network currently exists.[40]

COMPONENT	CORE JOB
Guam hub	Scale navigation and assessment; organize imaging/specialist protocols; support Guam families.
Saipan hub	Own the CNMI pathway; provide case review and coordination for Saipan/Tinian; manage off-island escalation.
Tinian spoke	Provide recognition, core work-up, tele-consult setup, caregiver support and transport continuity.
Shared layer	Training, forms, minimum data, case conference, quality measures and an annual learning report.

DESIGN PRINCIPLE

Standardize the promise and the information—not every island's staffing model. The service should feel coherent to a family even when care crosses agencies or islands.

Start with an operating agreement, not a new building

WINDOW	DELIVERABLE
0–30 days	Name Guam and CNMI leads; name Tinian coordinator; adopt evidence definitions; map current referral contacts and failure points.
31–60 days	Agree on first-visit work-up, urgent red flags, consent/preferred-language fields, specialist review schedule and escalation rules.
61–90 days	Pilot one referral form and tracker; enroll a small cohort; hold first cross-island case conference; publish baseline measures.

The 90-day test cohort

- Include at least one primary-care site and one aging/community entry point in Guam and Saipan, plus Tinian Health Center.
- Accept people with a memory concern, not only those already diagnosed.
- Record time to contact, time to memory visit, work-up completion, caregiver identification and next-step completion.
- Review every stalled referral in a weekly huddle; change the workflow immediately when the cause is operational.
- Protect small-cell privacy; report Tinian cases in aggregated or suppressed form.

SUCCESS AT DAY 90

The islands can show, with de-identified data, that a memory concern entered a visible pathway, received a timely first assessment, and reached a documented next step—with the family knowing who is responsible.

08B / ROADMAP

Build reliability first, then expand diagnostic depth

PHASE	FOCUS	VISIBLE OUTPUT
NOW–6 MONTHS	Governance + pathway	Leads, Tinian coordinator, forms, navigator role, first-work-up standard, tele-case conference, entry-point directory
6–18 MONTHS	Operational scale	More primary-care sites, caregiver curriculum, closed-loop aging-service referrals, visiting clinics, transport agreements
BY 2030	Service promise	5-day navigator contact; 30-day memory visit; named caregiver; annual dashboard; equitable island access
2030–2050	Depth + resilience	Workforce pipeline, home/respite capacity, crisis alternatives, diagnostic/therapy readiness, disaster continuity

Decision gates

BEFORE EXPANDING...	VERIFY...
Specialist volume	Core work-ups are complete and consult recommendations return to primary care.
Biomarker testing	Results will change management; counseling, consent and confirmatory pathways exist.
Anti-amyloid treatment	Financing, amyloid confirmation, infusion, serial MRI, ARIA response and travel reliability.
New data platform	Minimum fields and workflow are stable; privacy roles and reporting rules are agreed.
New facility	Navigation, home support, respite and referral completion cannot meet need through existing assets.

NO-REGRET SEQUENCE

Care coordination, caregiver support, primary-care competence and measurement benefit people now and remain necessary even as diagnostics and therapies change.

08C / THE DASHBOARD

Measure whether families actually receive care

DOMAIN	CORE MEASURE	REVIEW
Reach	Concerns received by island and entry point	Monthly; public annually
Timeliness	% navigator contact ≤5 days; memory visit ≤30 days	Monthly
Assessment	% with informant/function/medication/mood/sensory review and indicated tests completed	Quarterly
Caregiver	% with named caregiver/contact; strain measured; education and plan documented	Quarterly
Safety	% with documented urgent-risk and home-safety plan	Quarterly
Referral	% tele-specialist/off-island/aging-service referrals completed; median elapsed days	Quarterly
Experience	Person/family knew who to call; understood plan; language needs met	Twice yearly
Equity	Compare completion by island, age band, preferred language and payer—using suppression rules	Annually

ONE NUMERATOR DISCIPLINE

Publish both the number of people and the percentage completing each step. Percentages alone can hide a tiny denominator; counts alone can hide unequal completion.

ANNUAL LEARNING QUESTION

What changed because the dashboard showed a problem? A metric without an owner, review date and corrective action is only reporting.

USEFUL ENTRY POINTS

Public contacts to verify at the time of use

RESOURCE	ROLE	PUBLIC CONTACT
Alzheimer’s Association Hawai’i	Education, support and 24/7 Helpline; service area includes Guam and CNMI	800-272-3900 alz.org/hawaii
UOG Telehealth Geriatric Support Services	Guam/Micronesia dementia support and caregiver education	671-735-2883 gwep.tgss@triton.uog.edu
Guam DPHSS Division of Senior Citizens	Aging and community-support entry point	dphss.guam.gov/bureau-community-supports-bcs
CNMI Office on Aging	Meals, transport, senior centers and caregiver-support functions	670-233-1321/22 cnmiooa.org
CHCC / Saipan	CNMI hospital and outpatient/public-health anchor	670-234-8950 chcc.health
Tinian Health Center	Primary care, emergency, telehealth and inter-island referral	670-433-9337 / 9263 / 9333 / 9233

Before a memory appointment

- Bring a relative or friend who knows the person well and can describe changes over time.
- Bring every medicine and supplement—or an up-to-date list, including sleep and allergy products.
- Write down two or three specific examples: missed bills, getting lost, medicine errors, changed behavior or lost ability in a familiar task.
- Bring glasses and hearing aids; ask for discussion and the written plan in the preferred language.
- Ask what has been ruled out, what remains uncertain, who will call next and when follow-up should occur.

DO NOT WAIT FOR A ROUTINE VISIT

Sudden confusion, new weakness, severe headache, loss of consciousness or abrupt behavior change can be a medical emergency. Call 911 or seek urgent local clinical help.

Public program information and staffing can change. Verify availability before travel. This report is informational and is not medical advice.

How the estimates and service review were built

Population and age structure

Observed 2000, 2010 and 2020 island counts come from U.S. Census Island Areas files. Guam 2026/2030/2050 values come from UN World Population Prospects 2024 medium variant. Because the UN and Census bases differ, the projection seam is labeled. Saipan and Tinian have no standalone UN series; the report applies CNMI-wide UN growth factors for total population and each senior age band to the island's observed 2020 counts. Counts are rounded.[1–9]

Alzheimer's and all-dementia benchmark

Each year's residents are grouped into ages 65–74, 75–84 and 85+. The model applies 2026 U.S. clinical Alzheimer's prevalence of 5.2%, 13.8% and 35.8%. It sums age-band estimates, then divides by 0.70 and 0.60 for an all-dementia range; the midpoint divides by 0.65, following WHO's 60%–70% Alzheimer share. Holding rates constant isolates demographic effect. The range is not a confidence interval. Younger-onset cases are excluded.[10,11]

Life expectancy and risk

Life expectancy comes from UN WPP 2024; CNMI is shown only as a proxy for Saipan and Tinian. Guam risk indicators use the latest reportable 65+ values in CDC Healthy Aging records; years vary and confidence intervals are shown. CDC cognitive-health/caregiving records and comparable CNMI series were checked for availability.[9,14,15]

Service-capacity review

The review triangulated official program pages, federal shortage/provider data, peer-reviewed research, hospital imaging pages, Medicaid/GAO records and FDA labeling current through August 14, 2026. 'Not listed' or 'not verified' is not proof of absence. Provider registries can be stale and do not measure appointment availability.[16–38]

REPRODUCIBILITY

The calculation uses only published age bands and rates. A local analyst can replace any population scenario or prevalence assumption without changing the report's evidence categories.

09A / LIMITATIONS

What should not be inferred

- No completed representative island-specific clinical dementia prevalence study or complete diagnosis registry was located.
- U.S. age-specific Alzheimer's rates are not calibrated to CHamoru, Carolinian, Filipino or other local communities, and the model does not encode local protection or risk.
- UN and Census series have different bases. Future values are scenarios, not continuous measured time series.
- Saipan and Tinian scenarios assume their 2020 age-band shares evolve with CNMI-wide growth. Migration, military/construction activity, disasters and economic change could make the path very different.
- Tinian's very small age bands create large proportional swings from one or two people and require privacy-preserving reporting.
- The model excludes younger-onset dementia and does not separately estimate Guam ALS/PDC; it should not be added to clinical or claims counts without deduplication.
- BRFSS indicators are self-reported survey estimates from different years with wide intervals; they are not causal estimates of dementia.
- NPPES, HRSA and public websites do not measure wait times, affordability, quality, actual referral completion or current visiting specialists.
- The care scan does not verify every private, military, faith-based, informal or grant-funded service. Public entry points and phone numbers can change.
- The proposed 2030 targets and Marianas Memory Network are recommendations, not current service promises or funded programs.

USE THE BENCHMARK FOR

Sizing navigation, training, caregiver support, specialist sessions, transport and data infrastructure; testing alternative scenarios; asking which capacities must exist on each island.

DO NOT USE IT FOR

Diagnosing a person, calculating an entitlement, claiming actual diagnosed prevalence, ranking ethnic groups or asserting that a named treatment is currently available.

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Source review completed August 14, 2026. Web pages, program operations and provider records can change; verify before referral, travel or funding decisions.

MEMORY CARE SHOULD FEEL CLOSE— EVEN WHEN EXPERTISE MUST CROSS WATER.

A primary-care-led, family-supported and specialist-connected pathway can begin now.

Guam • Saipan • Tinian | 2000–2050