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When Memory Fades, Hawai'i Must Remember

Alzheimer's disease, dementia, and the future of our islands

Who carries the disease, how long the burden lasts, what state and federal government have built, and what Hawai'i risks if public support recedes.

"Memory may be what the disease takes. It must not be what government loses."

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Evidence current through August 29, 2026. The opening vignette is a composite. This paper is policy analysis and education, not medical or legal advice.

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Executive Summary

At 2:13 in the morning, the house is awake.

A daughter listens for her father's bare feet in the hallway. He believes he must leave for a job he retired from seventeen years ago. She turns on one lamp so the room will not feel threatening, calls him by the childhood name he gave her, and tells him the bus is late. It works tonight. At 6:30, after four broken hours of sleep, she will begin her own workday. Her father will not remember the hallway. Her body will.

This opening is a composite, not the story of one identifiable Hawai'i family. Yet its truth is repeated in apartments, plantation-era homes, multigenerational households, care homes, and rural communities across the islands. Dementia is often described as memory loss. That phrase is too small. Dementia can disturb judgment, language, perception, movement, personality, sleep, and the ability to perform ordinary tasks. Alzheimer's disease, the most common cause of dementia, is a progressive and ultimately fatal brain disease. It changes the life of the person, then reorganizes the life of everyone who loves and supports that person.

I am not a physician, and I do not write this from a clinical distance. I write as a Hawai'i resident, an Alzheimer's advocate, and someone who has spent long hours in legislative hearings, submitted testimony, and met with public officials about what families need. In those rooms, the language is bills, appropriations, referrals, and reporting dates. At home, the language is fear, exhaustion, money, and love. This paper is my attempt to keep those two worlds in the same frame.

The numbers are not neat. I wish they were. The best public estimates do not perfectly agree, which itself reveals the problem of underdiagnosis and incomplete data. The Alzheimer's Association reports approximately 31,000 Hawai'i residents age 65 and older living with Alzheimer's; the Hawai'i Department of Health has cited an estimated 35,000 residents affected and cautioned that the number is believed to be underreported. The state also has about 62,000 unpaid dementia caregivers providing 111 million hours of care valued at approximately \$3.3 billion. On average, that arithmetic is about 34 hours of care per caregiver every week, though the burden is not distributed evenly and some families provide continuous supervision. Alzheimer's-related Medicaid spending is already estimated at \$323 million. [1][2]

Hawai'i is also entering a demographic squeeze that is often summarized as "young people leave and older people move in." The evidence supports only part of that sentence. Hawai'i-born adults ages 18–24 have experienced persistent net out-migration, but recent Census-based analysis finds net gains among ages 25–44 and a post-pandemic return of many Hawai'i-born working-age residents. Older adults do move to Hawai'i, yet migration among Hawai'i-born people 65 and older has been roughly balanced in and out, and migrants overall tend to be younger than the resident population. The deeper truth is that Hawai'i is aging mainly because residents are aging in place, births have fallen, and children and working-age adults will make up smaller shares of the population. [30][31]

The human timeline is long. Brain changes associated with Alzheimer's may begin a decade or more—and sometimes 20 years or more—before symptoms become obvious. After diagnosis, a person lives an average of four to eight years, but may live as long as 20 years. Mild-to-moderate stages can last two to ten years; severe disease may last one to five. Caregiving often begins before a formal diagnosis and can continue for years, followed by bereavement, financial recovery, health consequences, and family repair that do not end on the day the person dies. [2][7][8]

I want to be fair about the record: Hawai'i has made meaningful progress. The state created a dementia services coordinator, required state-plan updates, established Silver Alert, standardized certain cognitive assessments, funded two dementia workforce positions at the John A. Burns School of Medicine, and in 2026 enacted the HANAI Memory Network. Act 245 placed HANAI within the Executive Office on Aging, authorized specialists and clinics, required referrals, public information, data, and annual reporting, and appropriated \$3 million for fiscal year 2026–2027. [4][11]–[16]

Federal law has built the national scaffolding: a National Alzheimer's Project and plan, research-budget accountability, BOLD public-health infrastructure, a family-caregiving strategy, Medicare cognitive assessment and care-planning benefits, and the eight-year GUIDE dementia-care model. BOLD funds support the Hawai'i Dementia Initiative, and Straub Benioff Medical Center's Geriatrics Clinic is a GUIDE participant serving local people with dementia and caregivers. [5][17]–[23]

Still, I have learned to watch the verbs in government documents. "Authorized" is not "available." A pilot is not a permanent system. A website is not a care navigator. The 2025 HANAI policy infographic envisioned one specialist in every county, a memory clinic in each neighbor-island county, and a recurring \$3 million annual budget. Act 245 created the framework and a one-year appropriation, but says the program "may" establish specialists and "one or more" clinics. It does not guarantee that county coverage or funding after fiscal year 2026–2027. [4][6]

That leads to the central conclusion of this paper:

The biggest help Hawai'i needs now is a permanent, accountable, statewide dementia continuum—an open front door in every county that connects early concern to diagnosis, treatment, care planning, caregiver training, respite, crisis support, and long-term services for the full course of the disease.

The immediate state priority is recurring funding to fully implement HANAI beyond fiscal year 2026–2027, with minimum county coverage and public performance measures. Federal priorities are to protect the research, Medicare, Medicaid, Older Americans Act, Administration for Community Living, and BOLD investments supporting Hawai'i; enact provider-training legislation such as the AADAPT Act; and create a Medicare pathway for appropriate blood-based dementia screening through the bipartisan ASAP Act. Detection without a trained provider and a place to land can be frightening. A care network without adequate detection and reimbursement can be an empty promise. Hawai'i needs both.

If state and federal support recedes, the "doomsday" future will not arrive as one dramatic event. It will arrive as thousands of ordinary emergencies: missed diagnoses, preventable hospitalizations, frightened encounters with first responders, exhausted caregivers leaving the workforce, family savings depleted by care, and neighbor-island residents traveling or going without. Act 245's own findings warn that Hawai'i's older adult population is expected to double in 25 years; more than 62,000 people may be living with Alzheimer's by 2050; memory-care capacity is already constrained; private memory care can exceed \$15,000 a month; and Medicaid spending could approach \$1 billion each year without intervention. [4]

I do not believe Hawai'i is powerless before that forecast. We have a plan, a coalition, new laws, local expertise, a tradition of kuleana, and the beginnings of a statewide network. The choice now is whether government will treat those beginnings as a temporary project or as essential infrastructure. Memory may fade. Public responsibility must not.

1. Understanding the Disease Without Losing the Person

Dementia is a condition; Alzheimer's is a cause

Dementia is an umbrella term for a decline in cognitive and behavioral abilities severe enough to interfere with daily life. Alzheimer's disease is the most common cause, but it is not the only one. Vascular dementia, Lewy body dementia, frontotemporal disorders, and other conditions can produce different patterns of change. Many older adults have mixed dementia, meaning that more than one disease process is present. [7]

That distinction can sound like medical fine print. It is not. It prevents every memory concern from being treated as inevitable Alzheimer's, and it reminds clinicians to look for depression, medication effects, sleep disorders, vitamin deficiencies, thyroid problems, infection, stroke, sensory loss, and other potentially treatable contributors. It also matters emotionally. A diagnosis is not a verdict that every ability disappears at once. A person can have impaired short-term memory and still feel music deeply, recognize kindness, respond to familiar touch, make preferences known, and contribute to family life.

The person is not "gone" when a test score falls. The disease may alter access to memories, words, and judgment, but personhood is not measured by recall. Dignity does not depend on productivity. Citizenship does not expire when someone needs help bathing or balancing a checkbook. Any system worthy of Hawaii must begin there.

What Alzheimer's changes

Alzheimer's involves progressive damage to brain cells and their connections. Early changes often affect regions central to learning and memory. As damage spreads, it can interfere with language, reasoning, spatial awareness, behavior, movement, swallowing, and basic bodily functions. In mild disease, a person may repeat questions, get lost on a familiar route, mishandle bills, or struggle to organize tasks. In moderate disease, confusion and communication problems deepen; dressing, medication management, cooking, toileting, and safety may require supervision. In severe disease, the person may lose the ability to communicate reliably, recognize loved ones consistently, walk, eat safely, or care for themselves. [7]

The progression is not a clean staircase. There are good mornings and frightening evenings. Illness, dehydration, pain, unfamiliar surroundings, or a change in caregiver can cause a sudden decline. A person may be fluent in one moment and unable to find a simple word in the next. Families often live in the space between what the person can do, what the person believes they can do, and what is actually safe.

Newer disease-modifying treatments have made early and accurate diagnosis more consequential for some people in the earliest clinical stages, but they are not cures, are not appropriate for everyone, and require specialized assessment and monitoring. Symptom treatments, management of other health conditions, environmental changes, caregiver training, exercise, meaningful activity, and social connection remain central. Early diagnosis also creates time for the person to participate in decisions about finances, advance care planning, driving, housing, treatment, research, and who they trust to speak for them. [7]

The ethical purpose of diagnosis is therefore larger than attaching a label. It is to replace confusion with an explanation, identify what may be treatable, preserve agency while it can be exercised, and connect a household to a continuing system of care.

2. Who Is Affected—and How

The person living with dementia

One of the easiest mistakes in dementia policy is to begin with everyone around the person and forget the person. I do not want this paper to make that mistake. The first person affected is the person whose brain is changing. The person can experience fear before anyone names the problem: the unsettling moment when a familiar street feels foreign, when a word disappears mid-sentence, or when others begin speaking around them instead of to them.

The losses are practical and intimate. A person may lose a driver's license, a professional role, control of money, privacy in personal care, or the right to be alone. Friends may pull away because they do not know what to say. Businesses may misread confusion as intoxication or dishonesty. First responders may interpret fear as defiance. A person who once managed a household may be corrected all day long. Shame and stigma can delay medical attention until a crisis forces it.

Younger-onset dementia, which develops before age 65, can be especially destabilizing. The person may still be working, paying a mortgage, raising children, caring for their own parents, or lack eligibility for age-based services. A spouse may become the primary earner and caregiver at the same time. Children may grieve a parent who is physically present but increasingly unable to fill the expected role.

Even in advanced disease, suffering is not the only human truth. Familiar music can calm. A lei, a prayer, a photograph, a beloved food, the cadence of a first language, ocean air, or a hand held without hurry can still communicate belonging. Quality of life is not an all-or-nothing outcome. Good dementia care keeps asking what comfort, purpose, relationship, and choice remain possible today.

The family

No family holds a meeting and votes to become a care system. It happens one task at a time, usually without warning, training, or agreement. A spouse becomes a medication manager, transportation coordinator, behavioral-health responder, legal advocate, and night watch. An adult child may become responsible for money, bathing, appointments, and decisions that feel like betrayals even when they are necessary. A grandchild may learn to redirect a beloved kūpuna before understanding the word “dementia.”

Families often experience ambiguous loss: the person is present, but the familiar relationship is changing. Grief arrives in installments—after the first missed birthday, the last independent drive, the moment a spouse is called by the wrong name, the move to a care home, the loss of speech. Because the person is still alive, the family may feel guilty for grieving. Because there are moments of recognition, hope and heartbreak can coexist in the same conversation.

Money and power complicate love. Siblings may disagree about whether a parent is safe alone, who should hold financial authority, whether to pursue an expensive treatment, or whether institutional care is necessary. The relative who lives closest may carry most of the labor while distant relatives criticize decisions. Family assets intended for housing, education, or the next generation can be consumed by care. Act 245 states that memory care in Hawai'i can cost more than \$15,000 per month, or \$180,000 per year—well beyond the reach of most households. [4]

The family's risk does not end with finances. Dementia can expose a household to scams, exploitation, unsafe driving, wandering, falls, medication errors, kitchen fires, and conflict over capacity. Legal planning delayed until a crisis can leave families in court or unable to act. Early care planning is not merely paperwork; it is a way to preserve the person's voice and reduce later conflict.

The unpaid caregiver

The word “unpaid” is accurate, but it is strangely bloodless. These hours are paid for—in sleep, earnings, health, privacy, and time that never comes back. Hawai'i's approximately 62,000 unpaid dementia caregivers provide 111 million hours of care valued at about \$3.3 billion. Dividing those totals yields roughly 1,790 hours per caregiver per year—about 34 hours every week—on top of paid work, parenting, household responsibilities, and the caregiver's own aging. An average conceals extremes: some caregivers provide a few hours of help; others cannot leave the person alone. [1]

Caregiving includes visible tasks such as bathing, dressing, meals, transportation, and medication. It also includes invisible vigilance: listening at night, checking the stove, hiding car keys, answering the same question without showing frustration, anticipating an exit, watching for swallowing trouble, and making ten small safety decisions every hour. The caregiver becomes the memory of the household—remembering appointments, preferences, histories, passwords, promises, and who the person was before the disease.

National public-health data show the consequences. Dementia caregivers face higher risks of anxiety, depression, and poorer quality of life. Nearly one in three family dementia caregivers provides care for four years or longer; about 80% of adults with Alzheimer's and related dementias receive care at home. More broadly, nearly two in ten employed caregivers report having to stop working, four in ten reduce their hours, and dementia caregivers report almost \$9,000 in average annual out-of-pocket costs in the cited study. [9][10]

“Resilience” can become a dangerous compliment when it is used to excuse abandonment. Love cannot replace sleep indefinitely. Kuleana cannot substitute for respite. A caregiver who collapses from exhaustion, postpones cancer screening, develops depression, or loses retirement savings becomes a second patient created by the first disease.

Paid caregivers, clinicians, employers, and communities

Dementia reaches far beyond the household. Direct-care workers manage complex needs for modest wages in a high-cost state. Primary-care clinicians may see the first warning signs but lack time, training, or a specialist to consult. Emergency departments become the default when behavior, dehydration, infection, falls, or caregiver exhaustion reaches a breaking point. Hawai'i Medicare data from 2010–2019 found that beneficiaries diagnosed with Alzheimer's disease and related dementias had 4.3 times as many inpatient stays and 2.7 times as many emergency-room visits as beneficiaries without a diagnosis; average annual Medicare costs were more than \$12,000 higher. Those data exclude undiagnosed residents, Medicare Advantage members, and long-term-care costs, so they do not represent the full burden. [3]

Employers absorb absenteeism, reduced hours, turnover, and the loss of experienced workers. First responders encounter wandering, fear, and communication difficulty. Financial institutions face exploitation and unusual transactions. Courts face questions of capacity and guardianship. Schools and young families feel the effect when middle-aged adults are simultaneously caring for children and kūpuna.

This is why dementia policy cannot sit inside a single health program. It is also workforce policy, housing policy, transportation policy, public-safety policy, Medicaid policy, economic policy, and community design.

3. How Long Are People Affected?

The honest answer is longer than most systems are built to support. I wish there were a cleaner answer. There is not.

Phase	Typical time horizon	What the person may experience	What family and systems must provide
Biological change before symptoms	A decade or more; changes may begin 20+ years before diagnosis	No obvious impairment, or subtle changes that are easy to dismiss	Risk reduction, stigma-free awareness, trusted primary care, research, and readiness to evaluate concern [2][7][8]
Early concern / mild cognitive impairment	Months to years; not everyone progresses	Memory, language, planning, or spatial problems; fear and uncertainty	Assessment for reversible causes, validated testing, diagnosis when appropriate, counseling, legal and financial planning [7]
Mild-to-moderate Alzheimer's	Often 2–10 years	Increasing difficulty with work, money, driving, medication, communication, and daily tasks	Treatment, navigation, caregiver training, respite, home safety, transportation, adult day care, and crisis prevention [8]
Severe Alzheimer's	Often 1–5 years	Dependence for personal care; impaired speech, mobility, eating, and recognition	Continuous care, skilled symptom management, caregiver relief, palliative care, hospice, or residential care [7][8]
Caregiver aftermath	Can continue years after death	Bereavement for the family; no disease phase for the person	Health recovery, grief support, financial repair, and recognition of the caregiver's own losses

The ranges above are not clocks. Vascular health, age at diagnosis, coexisting illness, type of dementia, treatment, social conditions, and individual biology all matter. Some families travel the course quickly; others provide care for a decade or more. The same family may need different systems at different stages: diagnostic access early, help with driving and legal planning next, respite and home modifications later, then intensive personal care, palliative care, hospice, or a residential setting.

This long trajectory explains why one-time grants and short pilots are structurally mismatched to dementia. A two-year program can demonstrate a model, but a family cannot time a ten-year disease around a fiscal sunset. Continuity is a clinical need. It is also an emotional need: people disclose fear, history, culture, and family conflict to a trusted navigator. When a grant ends and the navigator disappears, the family does not simply lose a service; it must begin again.

4. Why Hawai‘i Changes the Experience

Geography can turn a referral into a journey

On O‘ahu, specialty care may still require long waits, transportation, and time away from work. On a neighbor island, the same referral may involve an interisland flight, ground transportation, lodging, a companion, and the stress of moving a cognitively impaired person through unfamiliar places. Telehealth can reduce travel, but it cannot replace every neurological examination, scan, infusion, laboratory test, or face-to-face assessment. Broadband, hearing, vision, language, and caregiver availability also shape whether telehealth works.

Act 245 expressly recognizes limited access to early diagnosis, care planning, and long-term support in rural and neighbor-island communities because of geographic isolation, workforce shortages, and fragmented service delivery. The Hawai‘i Dementia Initiative likewise reports that residents may need to travel to O‘ahu for diagnosis and disease-modifying treatment, and recommends memory clinics on every island. [4][5]

In an island state, “statewide” cannot mean a Honolulu office with a toll-free number. It must mean a local human being who can answer the next question, a clinical pathway that reaches each county, and contracts that make specialized care available without requiring every family to cross the ocean.

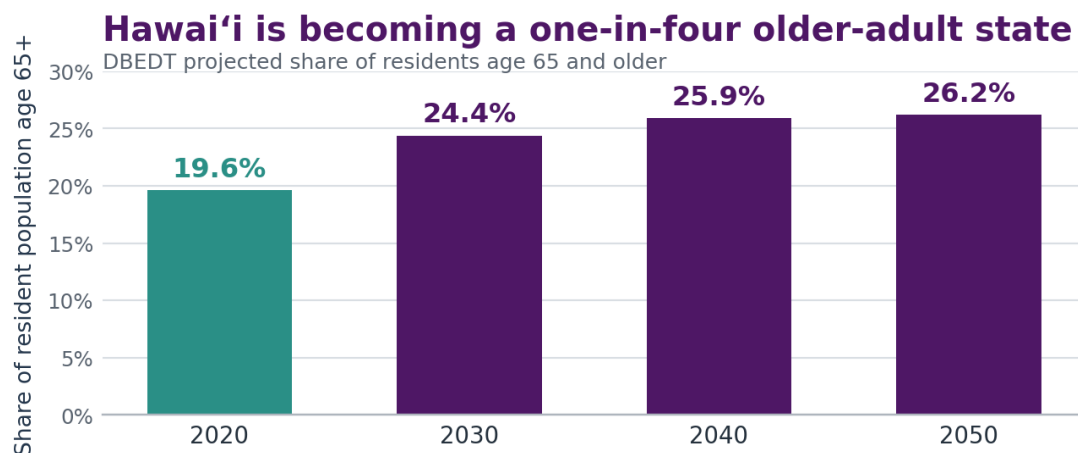
The demographic squeeze is real—even if the slogan is too simple

I have heard the same sentence more than once in meetings with Hawai‘i legislators: young people leave, and older people move here. It captures a genuine anxiety. It is also too simple to carry the weight placed on it.

Verdict: Partly true. Hawai‘i-born adults ages 18–24 remain net out-migrants, and there is notable in-migration among people 65 and older. But the strongest recent net gains have come from ages 25–44; Hawai‘i-born people 65 and older have had roughly equal inflow and outflow; and migrants overall have a younger age structure than the state’s resident population. [30][31]

UHERO’s Census-based analysis through 2023 found that more Hawai‘i-born people returned than left that year—about 12,100 arrivals compared with 6,400 departures. The pattern still differed sharply by age: net migration remained negative for Hawai‘i-born adults ages 18–24, while ages 25–44 posted a notable gain. The authors caution that Hawai‘i’s smaller sample sizes create large margins of error, so the evidence should be read as a pattern, not a head count carved in stone. [30]

The state’s aging trend nevertheless is unmistakable. DBEDT reports that while Hawai‘i’s total population grew 6.3% from 2010 to 2020, the population age 65 and older grew 44.4% and reached 19.6% of residents. DBEDT projects the 65-plus share to reach 24.4% in 2030, 25.9% in 2040, and 26.2% in 2050. At the same time, the number of children ages 0–17 is projected to fall by 27,000 between 2020 and 2030, and the working-age share is projected to decline from 60.0% in 2020 to 56.4% in 2050. [31]



Source: Hawaii DBEDT 2050 Series [31]. These are projections, not targets or guarantees.

Figure 1. Hawaii's population is aging even though migration itself generally skews younger. The demographic pressure comes principally from aging in place, lower births, and changing age shares.

Those shares imply an illustrative decline from about 3.1 working-age residents for every resident age 65 or older in 2020 to about 2.2 by 2050. That is not a caregiver ratio: many working-age adults will be raising children, holding multiple jobs, living with disabilities, or residing far from an older relative. It is a pressure signal. Just when dementia prevalence, diagnostic need, home care, and long-term-care demand rise, the share of residents available to staff services, pay taxes, and provide family care becomes smaller.

To me, this is the real warning. Hawaii must retain and welcome young adults, make it possible for working-age families to return and remain, and build a professional dementia-care system that does not assume every kūpuna has an adult child nearby with time, money, housing, and health enough to provide years of care.

'Ohana and culture are strengths—but not free labor

Hawaii's cultures carry deep respect for kūpuna and strong traditions of family care. Kuleana can give caregiving meaning, and 'ohana can distribute tasks across generations. Cultural practices, spiritual life, familiar foods, language, place, and community relationships can protect dignity and reduce distress.

But it is harmful to romanticize family caregiving. Cultural devotion does not create more hours in a day, pay a lost wage, or lift a person safely from bed. Families may delay outside help because of stigma, privacy, fear of dishonoring an elder, mistrust, or the belief that accepting help means failing in their responsibility. A system that assumes "the family will handle it" converts cultural strength into a budget subsidy.

Hawaii has begun building culturally responsive approaches. The Executive Office on Aging reports implementation of a Native Hawaiian road map; talk-story sessions; 'Auamo Ke Kuleana 'O Nā Ma'i Poina, a Native Hawaiian adaptation of the Savvy Caregiver program; locally tailored Dementia Friends materials; outreach to Filipino and Japanese communities; and resources in multiple Asian and Pacific languages. [5] These are not decorative additions. If an assessment tool, care plan, or caregiver class does not fit the language, history, and values of the household, access on paper may still be exclusion in practice.

The workforce and long-term-care market are already strained

Hawaii's Executive Office on Aging reported staffing shortages among providers that directly constrained chore and case-management capacity. The same annual report describes growing demand across home and community-based services. Act 245 states that long-term-care infrastructure is at or above capacity and memory-care beds are in short supply. [4][5]

This produces a cruel sequence. Families are encouraged to keep a person safely at home but cannot obtain enough paid help. When home care collapses, residential options are scarce and extraordinarily expensive. The emergency department then becomes the holding environment for a social-care failure it was never designed to solve.

Workforce policy must therefore include physicians, nurse practitioners, nurses, social workers, psychologists, pharmacists, direct-care workers, community health workers, care navigators, adult-day staff, respite providers, first responders, and culturally trusted community organizations. Hawaii cannot specialise its way out of dementia. It must make primary care and community care dementia-capable while preserving specialist backup for complex diagnosis and treatment.

5. What Government Has Done to Date

In advocacy meetings, I have learned to ask three questions whenever a bill passes: Who owns the work? Who pays for it after the announcement? Can a family on a neighbor island actually reach it? Government has not ignored dementia. Hawaii and the federal government have built important pieces over fifteen years. But families experience a pathway, not a list of statutes. A coordinator without county-level navigators, a screening without follow-up, a specialist without transportation, or respite without enough workers leaves the journey broken between pieces.

The following tables distinguish enacted law, implementation, and remaining gaps. Legislative status is current through August 29, 2026.

State of Hawai'i: enacted laws and implemented actions

Table 1. What state government has done, how it helps, and the largest remaining gap. Status current through August 29, 2026.

Action and status	What government did	How it helps	Biggest remaining gap
Act 214 (2013), SB 106; Act 127 (2019) ENACTED	Created and later sustained an Alzheimer's disease and related dementia services coordinator in the Executive Office on Aging; Act 214 also appropriated \$3.6 million for Kūpuna Care. [11]	Established a responsible statewide official and a bridge among public and private services.	One coordinator cannot substitute for county navigators, clinical capacity, or permanent program funding.
Act 146 (2018), HB 1916 ENACTED	Required biennial updates to the state ADRD plan, work plans with tasks and milestones, and progress reporting. [12]	Turned the plan into a living accountability document and supported the later Hawai'i 2035 strategy.	Reporting does not itself fund implementation; many actions still depend on grants and partner capacity.
Act 158 (2024), SB 2305 ENACTED	Established Silver Alert within the Department of Law Enforcement for missing people age 65+, cognitively impaired, or developmentally disabled; appropriated \$250,000. [13]	Creates a rapid public-safety mechanism for wandering and missing-person emergencies.	It responds after a person is missing; prevention, caregiver support, and dementia-trained response remain necessary.
Act 159 (2024), HB 2224 ENACTED	Required a comprehensive long-term-care plan and funded a planner position within the Executive Office on Aging. [29]	Recognized that dementia depends on the full continuum of home, community, and institutional care.	Planning must lead to funded beds, home-care capacity, workforce investment, and financing reform.
Act 283 (2025), SB 1252 ENACTED	Appropriated \$525,000 in each of FY2025–26 and FY2026–27 for two JABSOM geriatric-medicine positions, dementia curriculum, provider training, and annual reports. [14]	Builds a locally informed clinical workforce and coordinates dementia content across UH programs.	The appropriation is time-limited; training must extend to primary care, direct care, emergency care, and neighbor islands.
Act 286 (2025), HB 700 ENACTED	Standardized validated cognitive assessments for qualified Medicare beneficiaries and created a two-year, de-identified Dementia Data Pilot Program. [15]	Strengthens early detection and could reveal geographic and demographic gaps.	EOA reported the data pilot as unfunded; an abnormal screen still needs timely diagnosis, counseling, and care navigation.
Hawai'i 2035 plan, BOLD implementation, Healthy Brain Tracker (2023–2028) ACTIVE PROGRAMS	Built a 22-goal, 81-strategy, 161-action plan; convened the Hawai'i Dementia Initiative; launched a public data dashboard and culturally tailored education. [2][5]	Creates public-health infrastructure, shared priorities, local data, and community-clinical partnerships.	Current BOLD implementation support is temporary through 2028; EOA recommends a dedicated sustainable state fund.
Act 245 (2026), HB 1853 ENACTED	Established the HANAI Memory Network at EOA; authorized specialists, one or more clinics, referral directory, training, website, data, and annual reporting; appropriated \$3 million for FY2026–27. [4]	Creates Hawai'i's first statutory statewide pathway from early concern to diagnosis, care planning, and ongoing support.	The law says "may," guarantees neither county coverage nor neighbor-island clinics, and contains no appropriation beyond one fiscal year.
Act 246 (2026), HB 1973 ENACTED PILOT	Created a one-year KupunAloha in-home health and support pilot for eligible people who otherwise do not qualify for government assistance; sunsets June 30, 2027. [16]	Tests support for the middle-income coverage gap and may prevent premature institutionalization.	A one-year pilot is shorter than the disease trajectory; eligibility, scale, workforce, and continuation require evaluation and action.
Act 249 (2026), HB 1804 ENACTED	Directed EOA to define a study of public and private long-term-care financing options and report to the Legislature. [16]	Addresses the central mismatch between long disease duration and unaffordable custodial care.	A framework is not financing. Hawai'i needs a decision, implementation timetable, and middle-income protections.

Action and status	What government did	How it helps	Biggest remaining gap
Act 251 (2026), SB 2259 ENACTED	Established a DBEDT dementia-friendly business recognition program; requires one-hour employee training for recognition; appropriated \$90,000 for FY2026–27. [16]	Extends dementia capability into everyday commerce and can reduce stigma and unsafe interactions.	Participation is voluntary and start-up funding is one year; reach, quality, and renewal must be measured.

Federal government: enacted laws and active programs

Table 2. The federal foundation that supports research, public health, clinical care, aging services, and caregivers in Hawai'i.

Action and status	What government did	How it helps	Biggest remaining gap
National Alzheimer's Project Act (2011); reauthorized 2024 ENACTED	Created a coordinated national project, advisory council, and National Plan; Public Law 118-92 extended and modernized it through 2035, including risk reduction and healthy aging. [17][20]	Made Alzheimer's a continuing national policy responsibility rather than a collection of agency projects.	A plan needs annual appropriations, measurable state reach, and stronger translation from research into community care.
Alzheimer's Accountability and Investment Act (2024) ENACTED	Public Law 118-93 continued the annual NIH professional-judgment budget for research priorities and resources. [21]	Gives Congress an evidence-based estimate of the investment required to sustain scientific progress.	The estimate is not self-funding; Congress must appropriate enough to avoid stalled trials, lost talent, and delayed treatments.
RAISE Family Caregivers Act (2018) ENACTED	Required a national family-caregiving strategy and advisory council; the strategy now coordinates hundreds of federal and nonfederal actions. [18]	Recognized unpaid caregivers as a national policy constituency with health and financial needs of their own.	A strategy is not a guaranteed respite or income benefit; local service capacity and caregiver assessment remain uneven.
BOLD Infrastructure for Alzheimer's Act (2018); reauthorized 2024 ENACTED	Built CDC public-health centers, health-department grants, data, early detection, risk reduction, and caregiver infrastructure; reauthorized \$33 million annually for FY2025–29. [19]	Directly supports Hawai'i's 2020–23 planning grant and 2023–28 implementation grant, coalition, education, and data work.	Authorization still requires annual funding; Hawai'i's grant is temporary and needs a durable state successor.
Medicare cognitive assessment and care planning; Improving HOPE (2017–present) IMPLEMENTED	Annual Wellness Visits include detection of cognitive impairment; CPT 99483 supports a detailed assessment and written care plan. Federal outreach law promoted provider use. [22]	Creates a reimbursable clinical front door and can include caregiver information, safety, advance planning, and community referrals.	Utilization and follow-through remain uneven; screening must connect to diagnosis, treatment, navigation, and language access.
GUIDE dementia-care model (2024–2032) ACTIVE	CMS is testing comprehensive dementia care: interdisciplinary teams, navigation, 24/7 support, caregiver education, social-needs connections, and up to \$2,500 annual respite for qualifying participants. [23]	Straub Benioff Medical Center's Geriatrics Clinic is a Hawai'i participant, bringing a federal comprehensive-care model into the state. [5]	GUIDE is voluntary, time-limited, and closed to new applicants; access is not statewide and evaluation will determine permanence.
FY2026 federal appropriations ENACTED	Funded NIA at about \$4.518 billion and added \$100 million for Alzheimer's and related-dementias research across NIH. [24]	Sustains discovery, diagnostics, treatment, care, caregiving, and workforce research.	NIH estimates total FY2027 AD/ADRD research need at about \$4.05 billion; consistency matters because research cannot stop and restart cheaply.

Action and status	What government did	How it helps	Biggest remaining gap
Older Americans Act, ACL programs, Medicare, and Medicaid ONGOING FEDERAL FLOOR	Fund information and referral, meals, transportation, caregiver support, respite, benefits counseling, medical services, and much long-term care for people who qualify. EOA's FY2025 budget was 39% federal. [5]	These programs keep many people at home and make Hawai'i's aging-services network possible.	Medicare generally does not cover years of custodial care; eligibility gaps, workforce shortages, and potential funding reductions shift cost back to families.

The unfinished record: the help needed now

Table 3. Measures not yet enacted or funded that would close the most consequential gaps.

Action and status	What government did	How it helps	Biggest remaining gap
Recurring HANAI appropriation after FY2026–27 NOT YET ENACTED	Make at least the original \$3 million annual framework recurring; guarantee dementia-care-specialist capacity in every county and a diagnostic pathway in each neighbor-island county.	Prevents Act 245 from becoming an authorized network without enough people, clinics, or continuity.	This is the single most urgent state action.
H.R. 3747, AADAPT Act HOUSE PASSED; SENATE PENDING	Passed the House July 20, 2026; referred to Senate HELP July 21. Would reauthorize Project ECHO for FY2027–31 and explicitly include dementia care. [25]	Gives primary-care and rural clinicians specialist mentoring to diagnose and manage dementia locally.	Senate passage, enactment, and appropriations are still required.
H.R. 6130 / S. 3267, ASAP Act PENDING IN COMMITTEE	Would create Medicare coverage for qualifying FDA-cleared or approved blood-based dementia screening tests; House and Senate versions remained pending August 29, 2026. [26]	Could make appropriate early detection less invasive and more accessible, especially outside specialty centers.	Must be enacted and linked to counseling, confirmatory evaluation, trained providers, and a care pathway.
Hawai'i HB 1976 (2026) NOT ENACTED	Would have made at least one hour of dementia-specific training available for law enforcement, fire, and EMS and strengthened curriculum review. [27]	Could reduce escalation when a confused or frightened person meets emergency personnel.	Reintroduce with a funded, competency-based requirement and recurring refresher training.
Hawai'i HB 1597 (2026) NOT ENACTED	Would have established a UH/JABSOM ADRD research center and positions as a step toward stronger local and federal research capacity. [28]	Could address evidence gaps for Hawai'i's diverse populations and attract national partnerships.	Advance a phased, community-governed research strategy with stable start-up funds.

6. HANA: The Most Important State Opening in a Generation

What I like about the attached August 2025 HANA Memory Network infographic is that it makes the pathway understandable. Community outreach and primary care identify concern. A county-based dementia care specialist evaluates, educates, plans, and coordinates. A memory clinic provides clinical diagnosis and treatment. The person and family then move into ongoing primary, geriatric, neurological, and community care instead of being handed a diagnosis and left to search. [6]

That architecture addresses Hawai'i's central failure point: there has been no reliable bridge between noticing a problem and living with the answer.

Policy element	August 2025 HANA infographic	Act 245 as enacted July 2026—and the implementation consequence
County care navigation	One dementia care specialist in each county	Program may establish specialists. County minimum is not guaranteed; contracts and recurring funds must create it. [4][6]
Neighbor-island clinical access	One contracted memory clinic in each neighbor-island county	Program may establish one or more clinics. No island-by-island floor appears in the statute. [4][6]
Clinic team	MD/DO/APRN, registered nurse, and licensed social worker	The law defines clinics by function but does not prescribe this staffing model; procurement must protect interdisciplinary capacity.
Pathway	Outreach or primary care → evaluation → clinical diagnosis/care plan → continuing primary, geriatric, neurologic, and community care	Referral network, provider training, website, coordination, and data are authorized—strong foundations for the same pathway.
Financing	\$3 million annually from state appropriation and Medicaid reimbursement	\$3 million appropriated only for FY2026–27; no recurring appropriation or Medicaid financing mechanism is guaranteed. [4][6]
Accountability	Earlier diagnosis, equitable access, caregiver/provider support, fewer emergency visits and hospitalizations	Annual report must count screening, diagnoses, care plans, and satisfaction; utilization, equity, wait-time, and caregiver-strain measures should be added.

I support Act 245. It is a landmark because it gives the Executive Office on Aging a statutory home, authority to contract, a statewide referral function, provider training, a public-facing hub, data responsibility, and annual accountability to the Legislature. Its required report must include numbers screened and diagnosed, care plans created, and provider and caregiver satisfaction. [4]

Support does not require pretending that the final law guarantees more than it does. The words “may establish” preserve administrative flexibility, but they do not assure a dementia care specialist in each county or a clinic in each neighbor-island county. The \$3 million appropriation applies to one fiscal year. The infographic's proposed recurring annual budget and Medicaid reimbursement strategy did not become a permanent financing mechanism in the statutory text. [4][6]

I have spent much of my professional life watching large programs succeed or fail. The failure is rarely announced. It happens quietly: a program is launched, a website goes live, a few contracts are executed, demand outruns staffing, appropriations expire, and the public is told a service exists even though access depends on ZIP code, language, or knowing the right person.

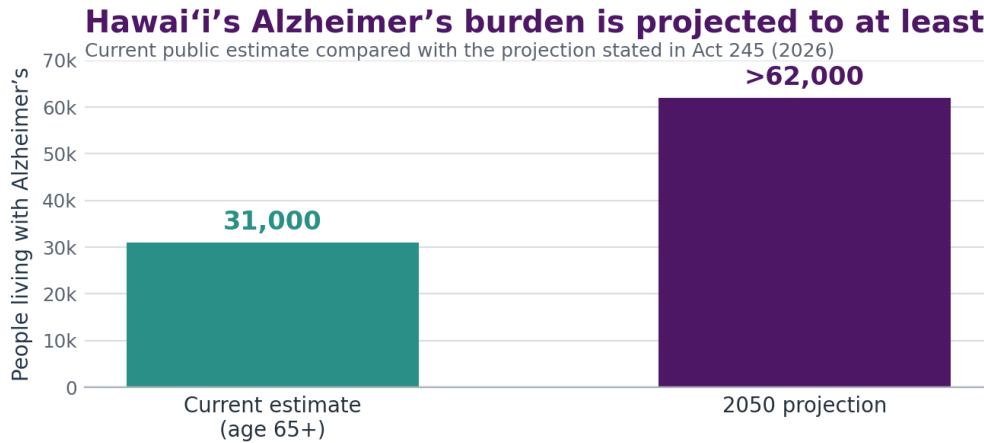
Hawai'i should prevent that outcome by treating fiscal year 2026–2027 as the build year, not the finish line. The original \$3 million annual proposal is less than 1% of the \$309 million in Alzheimer's Medicaid spending cited by Act 245 for 2025. That comparison does not prove savings, but it shows the modest scale of prevention-and-navigation investment beside the crisis costs the state already absorbs. [4]

The first annual HANAI report should be more than a count of activity. It should establish a public baseline for:

- time from first concern to cognitive assessment;
- time from abnormal assessment to diagnostic evaluation;
- number and location of dementia care specialists, clinics, and participating primary-care practices;
- access by county, rurality, race and ethnicity, language, age, disability, and living-alone status;
- care plans completed with the person and caregiver;
- caregiver strain, training, respite connection, and confidence;
- avoidable emergency-department visits, hospitalizations, and premature facility placement;
- access to palliative care, hospice, and culturally responsive services; and
- total state, federal, Medicaid, Medicare, health-system, and philanthropic dollars braided into the network.

Metrics are not bureaucracy when they reveal whether a family on Kaua'i, Maui, Moloka'i, Lāna'i, or Hawai'i Island can actually reach care.

7. The Outlook: Two Hawai‘is Are Now Possible



Sources: Alzheimer's Association Hawai'i state overview [1]; Hawai'i Act 245 (2026) [4]. Projection is not a count of all dementias.

Figure 2. Current estimate and the 2050 projection stated in Act 245. The 2050 value is more than 62,000; the chart uses 62,000 as a conservative floor.

When I look at the 2050 projection, I do not see a demographic curve first. I see workplaces, congregations, condominium hallways, rural towns, and extended families. More than 62,000 people living with Alzheimer's would make dementia ordinary across Hawai'i. The question is whether “ordinary” will mean supported or abandoned.

Domain	If support continues and matures	If support recedes or stays temporary
Early detection	A concern leads to assessment, diagnosis, counseling, and an actionable care plan in every county.	Screening identifies fear without a timely specialist, treatment decision, or navigator.
Caregiver	Training, respite, backup planning, and benefits support arrive before burnout.	Unpaid hours rise, workers reduce hours or leave jobs, and caregivers become patients.
Neighbor islands	Local specialist capacity plus telehealth and contracted clinics reduces travel and delay.	O'ahu concentration makes geography a clinical risk factor and families travel or go without.
Health system	Primary care manages more cases with specialist support; crises and avoidable use fall.	Emergency departments, law enforcement, and hospitals become the default dementia system.
Long-term care	Home care, adult day, palliative care, and sustainable financing preserve choice.	Scarce beds, \$15,000+ monthly memory care, unsafe home situations, and Medicaid spend-down dominate.
Public finance	Modest early investment is measured against avoided crisis, hospital, and placement costs.	Alzheimer's Medicaid spending approaches the state's projected \$1 billion annual threshold by 2050. [4]

The hopeful future is not one in which Alzheimer's disappears by 2050. It is one in which fewer people reach crisis without a diagnosis; more reversible contributors are identified; eligible patients reach treatment while it can matter; caregivers receive training and respite before burnout; first responders know how to de-escalate; and families can keep a person at home safely for as long as that remains appropriate.

The darker future is created not by the disease alone, but by delay and fragmentation. Dementia will progress whether a budget passes or not. The policy choice determines whether that progression is accompanied by guidance, safety, and shared cost—or by panic, preventable harm, and private ruin.

8. The Doomsday Forecast if Support Recedes

I use the word “doomsday” reluctantly. Fear can stigmatize people who are still living meaningful lives, and projections are not destiny. The people are not the catastrophe. The catastrophe would be knowing what is coming and asking families to face it alone.

The front door closes

If state funding for HANA ends after fiscal year 2026–2027, the program could remain in law while becoming thin in practice. County specialists may never reach full coverage. Neighbor-island memory clinics may remain aspirations. The referral directory may list services whose waits are months long or whose staff have left. Act 286’s standardized cognitive assessments may identify concern, but the two-year data pilot was reported as unfunded and an abnormal screen may still lead to no timely diagnostic appointment. [5][15]

That is a particularly dangerous form of failure: the public is encouraged to seek early detection, then discovers that the system cannot absorb the people who listened.

Care shifts back into the household

When navigation, adult day care, respite, home care, and caregiver training shrink, the work does not disappear. Government can remove the budget line; it cannot remove the need. The work moves into kitchens and bedrooms. Someone leaves work early. Someone turns down a promotion. Someone stops contributing to retirement. Someone sleeps with a chair against a door.

If the number of people living with Alzheimer’s roughly doubles from today’s approximately 31,000 to more than 62,000, and if today’s relationship between cases and unpaid care simply scales with it, Hawaii could face an illustrative burden of roughly 124,000 caregivers providing about 222 million unpaid hours valued near \$6.6 billion a year in today’s equivalent valuation. This is not an official forecast; it is transparent arithmetic based on today’s state figures. It shows what “the family will take care of it” could mean at 2050 scale. [1][4]

The demographic squeeze makes that arithmetic more dangerous. By 2050, the projected share of residents age 65 and older is larger while the working-age share is smaller. Without housing, wages, respite, paid leave, direct-care careers, and reliable navigation, Hawaii may lose potential caregivers not only to burnout but to the mainland. The state cannot build its dementia forecast on the assumption that an unlimited next generation will remain close enough—and financially secure enough—to absorb the work. [30][31]

Hospitals and first responders become the care plan

Without a strong community pathway, the emergency department becomes the place of diagnosis, respite, behavioral crisis management, and placement search. Yet Hawaii’s historical Medicare data already show far higher inpatient and emergency use among beneficiaries with dementia. [3] Emergency environments can intensify confusion: bright lights, noise, unfamiliar faces, long waits, sleep disruption, restraints, and rapid transitions.

First responders will increasingly meet people who are lost, frightened, unable to follow commands, or trying to return to a home that no longer exists. Hawaii enacted Silver Alert, but a 2026 proposal to provide at least one hour of dementia-specific training for first responders did not become law. A notification system helps find a missing person; trained interaction helps bring that person home without avoidable escalation. [13][27]

The long-term-care bottleneck becomes a humanitarian crisis

Act 245 describes memory-care beds as already scarce and private costs as more than \$15,000 per month. By 2050, a larger older population will be competing for direct-care workers, home-care hours, adult-day slots, assisted living, skilled nursing, and geriatric behavioral-health capacity. [4]

If public policy does not expand home and community-based services, pay and train the workforce, and create sustainable long-term-care financing, families will spend down savings until Medicaid eligibility, keep people at home beyond what is safe, or cycle through hospitals while searching for placement. Act 249's financing framework is therefore not peripheral to dementia; it is central to whether care exists.

Medicaid approaches the billion-dollar threshold

Hawaii law records Alzheimer's Medicaid spending rising from \$240 million in 2020 to \$309 million in 2025 and projects that, without intervention, the cost could approach \$1 billion each year by 2050. [4] That increase would compete with education, housing, climate resilience, public safety, and every other health priority. The false economy would be to cut navigation, caregiver support, and community care because they cost money, then pay much more for emergency, hospital, and institutional care after the household collapses.

Federal retreat multiplies state vulnerability

Washington can feel far away from Hilo, Lihue, or a family apartment in Honolulu. For dementia care, it is not. The Executive Office on Aging's state fiscal year 2025 budget was approximately \$20.8 million, with 39% coming from federal funds. Federal BOLD funding supports the Hawaii Dementia Initiative and its planning, data, public education, cultural adaptation, and coalition work; the current implementation grant is temporary through 2028. Federal Older Americans Act and Administration for Community Living dollars support core aging services. Medicare pays for cognitive assessment and care planning, while GUIDE is testing comprehensive dementia care, navigation, caregiver education, a 24/7 support line, and limited respite. Medicaid is the last payer for many long-term-care needs. [5][22][23]

If federal research, public-health, aging-services, Medicare, or Medicaid support is reduced, Hawaii cannot simply absorb the loss without consequences. The islands' small workforce and geographic fragmentation make duplication expensive. A cut in Washington can become a cancelled caregiver class in Hilo, a longer case-management wait on Kauai, less respite on Maui, or a family on Oahu told to call back next quarter.

Research retreat also has a human cost. NIH estimates that approximately \$4.05 billion in total Alzheimer's and related-dementias research resources will be needed for fiscal year 2027 to sustain progress. Slower research means slower development of prevention, diagnostics, treatments, and care models—and less evidence about communities historically underrepresented in research, including Asian American, Native Hawaiian, and Pacific Islander populations. [24]

Hawai'i loses more than money

Money is the easiest loss to count. It is not the only loss. Kūpuna hold language, family genealogy, recipes, songs, migration stories, fishing grounds, community history, and the memory of place. Dementia does not erase the value of a kūpuna, but a system that isolates that person or exhausts the family can break the transmission of knowledge between generations.

The doomsday scenario is therefore cultural as well as fiscal. It is a Hawai'i in which care depends on wealth and island, young adults leave the workforce or the state to survive, family conflict grows around impossible choices, and government counts crisis costs while the unpaid human cost remains off the books.

9. The Biggest Help Hawai'i Needs Now

If I had to reduce this entire paper to one request, it would not be for one more brochure, one more isolated pilot, or one more expectation that a primary-care clinician will solve a ten-year social and medical problem in a short visit.

Hawai'i needs a permanent dementia continuum with an accountable front door in every county.

1. Make HANAI recurring infrastructure

The Legislature should establish recurring, multi-year funding beyond fiscal year 2026–2027—at no less than the original \$3 million annual framework unless implementation data justify a different amount—and require minimum statewide coverage. Every county should have dementia care-specialist capacity. Every neighbor-island county should have a contracted clinical pathway capable of assessment, diagnosis, treatment planning, and continuing management, with telehealth used to extend rather than replace local care.

Funding should be braided with Medicaid reimbursement, Medicare care-planning benefits, GUIDE where available, health-system investment, federal grants, and philanthropy. But state core operations should not depend on winning the next grant. The Executive Office on Aging's own 2025 update recommends a dedicated, sustainable state funding source because BOLD funds are essential but temporary. [5]

2. Fund the caregiver as part of the care plan

Every dementia care plan should include an identified caregiver assessment when the person consents: the caregiver's health, sleep, employment, training needs, backup plan, safety concerns, and capacity to continue. Navigation should connect the household to respite, adult day services, home care, benefits counseling, legal planning, support groups, and culturally appropriate training.

Respite should be available before catastrophe, not only after a caregiver declares they cannot continue. Hawai'i's 62,000 unpaid caregivers are not a limitless reserve of labor. Supporting them is not charity. It is protection of the state's largest dementia-care workforce.

3. Make the workforce dementia-capable

Act 283's two JABSOM positions and curriculum work are an important beginning. Hawai'i should sustain those positions after the current appropriation period and extend training across primary care, nursing, social work, pharmacy, direct care, emergency care, adult day services, and community health. The state should revive

dementia-specific first-responder training and set practical competency standards, not just offer optional materials. [14][27]

At the federal level, the Senate should complete action on the AADAPT Act, which passed the House in July 2026 and would reauthorize Project ECHO while explicitly adding dementia care. A hub-and-spoke training model is well suited to an island state: local clinicians can manage more care with specialist mentoring rather than requiring every person to travel. [25]

4. Make early detection actionable and equitable

Act 286 and Medicare's Annual Wellness Visit cognitive-impairment check create opportunities to detect concern. But screening is not diagnosis, and diagnosis without follow-up is not care. The state should ensure that every abnormal screen has a defined referral, a reasonable maximum wait, communication in the person's preferred language, and support for transportation and interisland care. [15][22]

Congress should enact the bipartisan Alzheimer's Screening and Prevention Act, the ASAP Act, to establish a Medicare coverage pathway for appropriate FDA-cleared or approved blood-based dementia screening tests. As of August 29, 2026, H.R. 6130 and S. 3267 remained pending. Blood tests will not replace a comprehensive clinical evaluation, and broad use must follow evidence and informed consent. But coverage could reduce access barriers if it is linked to trained providers and a care network. [26]

5. Protect the federal floor

Hawaii's congressional delegation should defend and strengthen BOLD, NIH and NIA research, the National Alzheimer's Project, the Older Americans Act, the Administration for Community Living, Medicare cognitive assessment and care planning, GUIDE, and Medicaid home and community-based services. These are not distant federal programs; they are embedded in Hawaii's local data system, workforce, navigation, caregiver support, and clinical care.

6. Build research capacity that reflects Hawaii

Hawaii needs stronger local research infrastructure to understand dementia across its diverse populations and test culturally grounded interventions. A 2026 bill to establish an Alzheimer's disease and related dementias research center at the University of Hawaii did not advance beyond House Finance. Its premise remains sound: Hawaii's Asian American, Native Hawaiian, and Pacific Islander communities are underrepresented in much of the national evidence base, and local capacity can attract federal partnerships while improving care at home. [28]

Research must be done with communities, not merely on them. It should include language access, community governance, caregiver outcomes, rural and neighbor-island participation, and return of useful knowledge to the people who contributed it.

7. Finance long-term care before the market fails

Act 249's study of public and private long-term-care financing options should move quickly from framework to decision. Dementia is where the difference between Medicare and long-term care becomes painfully visible: Medicare covers medical services, but it generally does not pay for years of custodial supervision. A person can be medically stable and still require continuous assistance that costs more than the household earns.

Hawaii should evaluate a durable mix of public financing, private responsibility, caregiver protections, workforce investment, and home and community-based care. The aim should be to prevent impoverishment and preserve choice, not simply delay institutional placement at any cost.

10. A 24-Month Accountability Agenda

My professional life taught me that a plan without ownership, dates, measures, and accountability is not yet a plan. Dementia policy deserves that same discipline—and much more urgency, because the cost of delay is human. The next two years should convert law into a functioning pathway. The state and federal governments should be judged by whether families can feel the difference.

By the end of fiscal year 2026–2027

- HANAI should publish a county-by-county implementation map showing specialists, clinics, referral partners, wait times, languages, telehealth capacity, and transportation pathways.
- The Executive Office on Aging should execute contracts that guarantee neighbor-island diagnostic access and define how primary care, community health centers, specialists, and dementia care specialists share responsibility.
- The Legislature should appropriate recurring funds for the next biennium before the initial \$3 million expires.
- The state should integrate HANAI, Act 286 cognitive-assessment reporting, the Healthy Brain Tracker, Silver Alert, Kūpuna Care, palliative care, and long-term-care planning into one public accountability framework.
- Caregiver assessment, training, and respite connection should be measured as core outcomes, not optional referrals.
- DBEDT, EOA, and HANAI should publish a recurring demographic-capacity dashboard linking age-specific migration, the direct-care workforce, caregiver availability, and county-level dementia demand.

During the 2027 state legislative session

- Make HANAI's county coverage and annual funding durable.
- Reintroduce dementia-specific first-responder training with a funded implementation plan.
- Sustain the JABSOM dementia workforce positions and create continuing-education pathways for the broader health and direct-care workforce.
- Fund the dementia data pilot and require transparent, de-identified reporting.
- Advance a phased University of Hawaii ADRD research-center strategy tied to community participation and federal grant readiness.
- Act on the long-term-care financing analysis with explicit protections for middle-income families who are too "rich" for assistance and far too poor for \$180,000-a-year care.

In Congress

- Complete AADAPT Act passage and fund Project ECHO dementia training.
- Enact the ASAP Act with evidence-based coverage rules, clinical follow-up, equity safeguards, and appropriate counseling.
- Preserve or increase NIH/NIA Alzheimer's and related-dementias research investment and BOLD implementation funding.
- Protect Medicare GUIDE, cognitive assessment and care planning, Medicaid home and community-based services, the Older Americans Act, and Administration for Community Living caregiver programs.

This agenda is not a wish list of disconnected programs. It is one sequence: notice, assess, diagnose, explain, treat, plan, navigate, support, respond, and remain present through the end of life.

Conclusion: The Memory Hawai'i Must Keep

I keep coming back to the question dementia asks of every family: What remains when memory changes?

Love remains, but love becomes work. Humor remains, sometimes in flashes. Preference remains. Fear remains. Music, touch, ritual, faith, food, ocean, language, and the feeling of being safe can remain long after facts become difficult to retrieve. The person remains.

The public question is different: What remains when government attention changes? When a legislative meeting ends, the bill numbers go back into folders. The family does not go back to normal.

If funding is temporary, the navigator disappears. If training is optional, the frightened person may meet force instead of understanding. If diagnosis is available only on one island, geography becomes destiny. If respite is scarce, devotion becomes exhaustion. If long-term care is unaffordable, a lifetime of savings can disappear before the disease does.

Hawai'i has already named the alternative. The 2035 plan, the Hawai'i Dementia Initiative, Silver Alert, cognitive-assessment standards, workforce investment, GUIDE participation, and the HANAI Memory Network are pieces of a more humane future. Act 245's promise is that a person should not have to navigate dementia alone and a family should not have to invent a care system after a diagnosis.

Now the state must fund that promise for longer than one fiscal year, and the federal government must maintain the research, training, insurance, public-health, aging-services, and caregiver foundation that makes local action possible.

The doomsday forecast is not inevitable. It is the price of choosing temporary attention for a permanent demographic change.

I keep returning to the house where this paper began. At 2:13 tomorrow morning, another hallway will be lit. The measure of Hawai'i's policy will be whether the daughter standing there has a number to call, a trained person who answers, a safe place for her father to go, and enough help that love does not require her destruction.

Memory may be what the disease takes. It must not be what government loses.

Source Notes

Scope and method. Legislative status and program information are current through August 29, 2026. Enacted measures were checked against official session laws or signed-bill records. Pending measures are identified as pending or not enacted. The 2050 caregiver-hour scenario is illustrative arithmetic, not an official forecast. Differences between the 31,000 and 35,000 current estimates reflect different public sources, populations, and methods and underscore underdiagnosis and data limitations.

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- [2] Hawai'i Department of Health. "Hawai'i Launches Healthy Brain Tracker to Support Cognitive Health." June 30, 2025. [Source](#)
- [3] Hawai'i Dementia Initiative and Hawai'i Health Data Warehouse. Dementia Data Dashboard and Hawai'i 2035 plan summary; Medicare fee-for-service analysis, 2010–2019. [Source 1](#) [Source 2](#)
- [4] State of Hawai'i. Act 245 (2026), HB 1853 HD1 SD1 CD1, Relating to Dementia; approved July 14, 2026. [Source](#)
- [5] Hawai'i Department of Health, Executive Office on Aging. Annual Report for State Fiscal Year 2025, including the 2025 update to Hawai'i 2035 and policy recommendations. December 2025. [Source](#)
- [6] HANAI Memory Network. "Supporting 2026 Legislative Policy Initiatives" infographic. August 28, 2025. User-provided source document.
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- [8] Alzheimer's Association. "Brain Tour Part 2: Progression Through the Brain." Disease-duration ranges. [Source](#)
- [9] Centers for Disease Control and Prevention. "Caregivers of a Person with Alzheimer's Disease or a Related Dementia." September 3, 2024. [Source](#)
- [10] Centers for Disease Control and Prevention. "Dementia Caregiving as a Public Health Strategy." September 3, 2024. [Source](#)
- [11] State of Hawai'i. Act 214 (2013), SB 106, and Act 127 (2019), SB 366, establishing and sustaining the ADRD services coordinator. [Source 1](#) [Source 2](#)
- [12] State of Hawai'i. Act 146 (2018), HB 1916, requiring biennial state-plan updates and work plans. [Source](#)
- [13] State of Hawai'i. Act 158 (2024), SB 2305, establishing Silver Alert. [Source](#)
- [14] State of Hawai'i. Act 283 (2025), SB 1252 CD1, dementia curriculum, workforce positions, and appropriations. [Source](#)
- [15] State of Hawai'i. Act 286 (2025), HB 700 CD1, cognitive assessments and Dementia Data Pilot Program. [Source](#)
- [16] Hawai'i State Legislature. 2026 Acts register; Acts 246, 249, and 251. [Source 1](#) [Source 2](#) [Source 3](#) [Source 4](#)
- [17] United States. National Alzheimer's Project Act, Public Law 111-375, approved January 4, 2011. [Source](#)
- [18] United States. RAISE Family Caregivers Act, Public Law 115-119, approved January 22, 2018; Administration for Community Living caregiver strategy. [Source 1](#) [Source 2](#)
- [19] United States. BOLD Infrastructure for Alzheimer's Act, Public Law 115-406, and 2024 reauthorization, Public Law 118-142. [Source 1](#) [Source 2](#)
- [20] United States. NAPA Reauthorization Act, Public Law 118-92, approved October 1, 2024. [Source](#)
- [21] United States. Alzheimer's Accountability and Investment Act, Public Law 118-93, approved October 1, 2024. [Source](#)
- [22] Centers for Medicare & Medicaid Services. "Cognitive Assessment & Care Plan Services." [Source](#)
- [23] Centers for Medicare & Medicaid Services. "GUIDE (Guiding an Improved Dementia Experience) Model." [Source](#)
- [24] National Institute on Aging. Director's Status Report, May 2026, and FY2027 Professional Judgment Budget for Alzheimer's Disease and Related Dementias Research. [Source 1](#) [Source 2](#)
- [25] U.S. Congress. H.R. 3747, Accelerating Access to Dementia and Alzheimer's Provider Training (AADAPT) Act; engrossed in the House July 20, 2026 and referred to Senate HELP July 21, 2026. [Source 1](#) [Source 2](#)
- [26] U.S. Congress. H.R. 6130 and S. 3267, Alzheimer's Screening and Prevention (ASAP) Act; status current through August 29, 2026. [Source 1](#) [Source 2](#)
- [27] Hawai'i State Legislature. HB 1976 (2026), dementia-specific first-responder training; not enacted. [Source](#)

[28] Hawai'i State Legislature. HB 1597 (2026), proposed UH/JABSOM ADRD Research Center; not enacted. [Source](#)

[29] State of Hawai'i. Act 159 (2024), HB 2224, comprehensive long-term-care plan and planner position. [Source](#)

[30] University of Hawai'i Economic Research Organization. JoonYup Park, "Who Is Moving In and Out? Understanding Migration Trends in Hawai'i." April 2, 2025. Census-based analysis through 2023. [Source](#)

[31] Hawai'i Department of Business, Economic Development & Tourism. "Population and Economic Projections for the State of Hawaii to 2050," 2050 Series. [Source](#)

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