enrollment in the Care Ecosystem study, 97 caregivers of patients with dementia randomized to the intervention group were asked (1) whether patients premorbidly made their own purchases, paid household bills by themselves, or prepared taxes or other important documents; (2) if so, whether patients had performed these activities in the preceding year; and (3) if so, whether patients had made financial errors. 

Results: Among patients with mild disease, 26 of 43 (60%) who had previously made purchases continued to do so in the previous year, while 15/32 (47%) continued to pay bills and 5/21 (24%) continued to prepare taxes. One patient with moderate disease continued to pay bills and prepare taxes, suggesting high financial vulnerability. (Figure 1) Patients who had completed a college degree were more likely to continue to make purchases (p = 0.032) and to pay bills (p = 0.015). (Figure 2) Contrary to our initial hypotheses, living alone was not associated with continued financial activities. (Figure 3) Out of 35 still participating in financial activities in the preceding year, 11 were reported to have made financial errors.

Conclusions: Responses are consistent with a graduated restriction of financial activities with disease progression. We will discuss clinical experiences in the Care Ecosystem care navigation intervention of working with caregiver/patient dyads identified as vulnerable to financial errors. This publication was made possible by Grant Number 1C1CMS331346 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

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Although the total number of arrests of persons over 65 has been declining, it is the only age group in which arrests for violent acts has increased. If this development is in any way due to the increasing cases of dementia, a system that takes the possibility of dementia into consideration and protects the rights of living well with dementia is needed urgently. 

Methods: We have surveyed the details of violent acts by 211 consecutive new dementia out-patients in our Medical Centre, between January, 2016 and December, 2016. Results: Of 211 new outpatients, 12.8% (n=27) exhibited physical violence, and 27.0% (n=57) exhibited verbal violence. These accounted for 31 of 130 patients (23.8%) with AD, 9 of 41 patients (22.0%) with MCI, 7 of 27 patients (25.9%) with VD, 1 of 9 patients (11.1%) with DLB, none of 3 patients (0.00%) with bvFTD exhibited verbal violence. 5 of 12 patients (41.7%) with psychoactive substance use (alcohol, benzodiazepines) exhibited verbal violence while none of 21 patients (0.00%) within normal cognitive aging did. 

Conclusions: Most occurrences of aggressive behaviour did not involve serious violence, and were entered into impulsively. The impulsive nature of these acts is more likely to be connected to vulnerability in the frontal lobe of dementia. This further suggests the possibility that much of the violent behaviour for which persons over 65 are arrested is also similarly impulsive in nature, and includes acts by patients of undiagnosed dementia or MCI. If dementia patients are being arrested for violent behaviour without understanding of their condition, this suggests the necessity for a system that protects the rights and interests of these individuals.

Background: Cognitive impairment and physical frailty exacerbate older persons’ vulnerability and threaten their independence. We studied the pattern of these two conditions and their associated factors among the community-dwelling older adults of low socioeconomic status (SES).

Methods: A cross-sectional pilot study was conducted in older persons living in one-room apartments, the lowest form of public housing in our country. A questionnaire that elicited demographic information, frequency of participation in senior activity programmes, cognitive impairment (CI: Brief Informant Screening Test) and frailty (FRAIL scale) was applied. Latent class analysis (LCA) on the phenotypes CI and frailty was used to identify the number and profile of latent class groups within the sample. Subsequently, path analysis explored the hypothesized relationship of working and activity participation with LCA group as the outcome variable. 

Results: The participants’ mean age was 74.3±8.8 (n=192). Overall prevalence of CI and frailty was 42.71% (n=82) and 27.6% (n=53) respectively. LCA was derived from 18 categorical items on frailty, comorbidities and CI. A two-class LCA model was selected as best fitting (BIC = 2850.623, bootstrapped LRT p-value < 0.0001). Group 1 (n=94, 49%): frail (0%)and CI (28.7%) and Group 2 (n=98, 51%): frail (54.1%) and CI (56.1%). The model fit indices of the path analysis were RMSEA=0.000, CFI=0.96, and SRMR=0.03.