COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Adult Key Event Change (KEC)

Age Group: 26-59

ADMINISTRATIVE INFORMATION

Client ID ______ Client DOB ______

Episode ID ______ Provider Number ______ (4 characters)

Client Last Name ______ Client First Name ______

Partnership Date ______ Assessment Date ______

Partnership Service Coordinator (Last Name) ______ Assessment Completed By ______ (10 characters NPI #)

CHANGE IN ADMINISTRATIVE INFORMATION

(skip this section if there are no changes)

New Provider Number ______ (4 characters)

Date of Provider Number Change ______

New Partnership Service Coordinator (Last Name) ______

Date of Partnership Service Coordinator Change: ______

New Program Name (select one)

Date of Program Name Change: ______

- ◯ FSP-Adult
- ◯ FSP-Transitional Age Youth (TAY)
- ◯ FSP-Older Adult
- ◯ Assisted Outpatient-FSP (AOT-LA-FSP)
- ◯ Integrated Mobile Health Team-FSP (IMHT-FSP)
- ◯ Forensic FSP (F-FSP)

PROGRAM INFORMATION

In which program(s) is the client CURRENTLY involved? (check all that apply)

AB2034 PROGRAM

Date of AB2034 Program Change: ______

- ☐ Now enrolled in the AB2034 Program
- ☐ No longer enrolled in the AB2034 Program

GOVERNOR'S HOMELESS INITIATIVE (GHI) PROGRAM:

Date of Governor's Homeless Initiative Program (GHI) Change: ______

- ☐ Now enrolled in the GHI Program
- ☐ No longer enrolled in the GHI Program

MHSA HOUSING PROGRAM:

Date of MHSA Housing Program Change: ______

- ☐ Now enrolled in the MHSA Housing Program
- ☐ No longer enrolled in the MHSA Housing Program

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Name ______ IS# ______

Agency ______ Provider # ______

Los Angeles County - Department of Mental Health

CHANGE IN ADMINISTRATIVE INFORMATION *continued*

(skip this section if there are no changes)

Date of Partnership Status Change:

Indicate New Partnership Status:

- ◯ Discontinuation / Interruption of Full Service Partnership and/or community services / program **(Indicate the reason below)**.
- ◯ Reestablishment of Full Service Partnership and/or community services / program.

If there is a DISCONTINUATION / INTERRUPTION of Full Service Partnership and/or community services / program, indicate the reason (select one):

- ◯ Target population criteria are not met.
- ◯ Client decided to discontinue Full Service Partnership participation after partnership established.
- ◯ Client moved to another county / service area.
- ◯ After repeated attempts to contact client, he/she cannot be located.
- ◯ Community services / program interrupted - Client's circumstances reflect a need for residential / institutional mental health services at this time (such as an institution for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC), State Hospital).
- ◯ Community services / program interrupted - Client will be serving jail sentence.
- ◯ Community services / program interrupted - Client will be serving prison sentence.
- ◯ Client has successfully met his/her goals such that discontinuation of Full Service Partnership is appropriate.
- ◯ Client is deceased.

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LIVING ARRANGEMENTS

(skip this section if there are no changes)

Client has had a change in living arrangement? (check one in this column)	RESIDENTIAL TYPE	DATE OF CHANGE	Why did client change residential status? (select from choices at the bottom of the page)	If the move is due to a reason other than jail or hospital, in the opinion of the client, is this positive or negative change?	Do the client and staff personnel collaboratively view this as an appropriate change given the CURRENT needs and goals of the client? (select one for each selection)
GENERAL LIVING ARRANGEMENT					
☐	With adult family members other than parents (non foster care)			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	In an apartment or house alone / with spouse / partner / minor children / other dependents / roommate – must hold lease or share in rent / mortgage			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	With one or both Biological / Adoptive Parents			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Single Room Occupancy (SRO) (must hold lease)			◯ Positive ◯ Negative	◯ Yes ◯ No
SHELTER / HOMELESS					
☐	Emergency Shelter			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Homeless (includes people living in their cars)			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Temporary Housing (includes people living with friends but paying no rent)			◯ Positive ◯ Negative	◯ Yes ◯ No

Why did client change residential status?

1) Asked to leave by other(s)
2) At risk, sibling abuse
3) Caretaker / Absent or incapacitated
4) Decrease functioning
5) Decrease in financial status
6) Desired increase independence
7) Dissatisfied with prior living situation
8) Emotional abuse
9) General neglect
10) Health Reasons
11) Improved Functioning
12) Increase in financial resources
13) More affordable house / apartment
14) New / Better House / Apartment
15) Non-Payment of rent / evicted
16) Other
17) Physical Abuse
18) Sexual Abuse
19) Unable to maintain level of independence

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Agency ______ Provider # ______

Los Angeles County - Department of Mental Health

LIVING ARRANGEMENTS *continued*

(skip this section if there are no changes)

Client has had a change in living arrangement? (check one in this column)	RESIDENTIAL TYPE	DATE OF CHANGE	Why did client change residential status? (select from choices at the bottom of the page)	If the move is due to a reason other than jail or hospital, in the opinion of the client, is this positive or negative change?	Do the client and staff personnel collaboratively view this as an appropriate change given the CURRENT needs and goals of the client? (select one for each selection)
HOSPITAL					
☐	Acute Medical Hospital			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Acute Psychiatric Hospital / Psychiatric Health Facility (PHF)			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	State Psychiatric Hospital			◯ Positive ◯ Negative	◯ Yes ◯ No
RESIDENTIAL PROGRAMS					
☐	Alcohol or Substance Abuse Residential Rehabilitation Center			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Crisis Residential Housing			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Group Living Home			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Institution for Mental Disease (IMD)			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Long Term Residential Program			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Mental Health Rehabilitation Center (MHRC)			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Skilled Nursing Facility (physical)			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Skilled Nursing Facility (psychiatric)			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Transitional Residential Program			◯ Positive ◯ Negative	◯ Yes ◯ No
JUSTICE PLACEMENT					
☐	Jail			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Prison			◯ Positive ◯ Negative	◯ Yes ◯ No

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Agency ____________ Provider # ____________

LIVING ARRANGEMENTS *continued*

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Client has had a change in living arrangement? (check one in this column)	RESIDENTIAL TYPE	DATE OF CHANGE	Why did client change residential status? (selet from choices at the bottom of the page)	If the move is due to a reason other than jail or hospital. In the opinion of the client, is this positive or negative change?	Do the client and staff personnel collaboratively view this as an appropriate change given the CURRENT needs and goals of the client? (select one for each selection)
SUPERVISED PLACEMENT					
☐	Assisted Living Facility			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Licensed Community Care Facility (Board and Care)			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Sober Living Home			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants, etc.)			◯ Positive ◯ Negative	◯ Yes ◯ No
OTHER					
☐	Other			◯ Positive ◯ Negative	◯ Yes ◯ No
☐	Unknown			◯ Positive ◯ Negative	◯ Yes ◯ No

Why did client change residential status?

1) Asked to leave by other(s)
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Agency ________ Provider # ________

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Adult Key Event Change (KEC)

Age Group: 26-59

ADMINISTRATIVE INFORMATION

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FINANCIAL

(skip this section if there are no changes)

BENEFITS

Identify CURRENT status **(check all that apply)**:

- ☐ Medi-Cal
- ☐ Veteran's Assistance (VA) Benefits
- ☐ Private Insurance
- ☐ Medicare
- ☐ Participant in CalWORKs
- ☐ HMO

CHANGE IN PAYEE STATUS

Has the client been placed on Payee status? ○ **Yes** ○ **No**

Has the client been removed from Payee status? ○ **Yes** ○ **No**

Date of Payee Status Change:

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Name | IS#

Agency | Provider #

Los Angeles County - Department of Mental Health

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

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DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL

(skip this section if there are no changes)

GRADE LEVEL INFORMATION

Highest Level of Education Attained **(check one)**:

- ◯ No High School Diploma / No GED
- ◯ GED Coursework
- ◯ High School Diploma / GED
- ◯ Some College / Some Technical or Vocational Training
- ◯ Associate's Degree (e.g., A.A., A.S.) / Technical or Vocational Degree
- ◯ Bachelor's Degree (e.g., B.A., B.S.)
- ◯ Master's Degree (e.g., M.A., M.S.)
- ◯ Doctoral Degree (e.g., M.D., Ph.D.)

Date of Grade Level Completion: ________

EDUCATIONAL SETTING

If there are any educational setting changes, indicate ALL NEW and ONGOING statuses including those previously reported. **(check all that apply)**

- ☐ Not in school of any kind
- ☐ High School / Adult Education
- ☐ Technical / Vocational School
- ☐ Community College / 4 year College
- ☐ Graduate School
- ☐ Other

Date of Educational Setting Change: ________

Average number of HOURS PER WEEK in school (1-40) ________

If the client is in some way STOPPING school or training (e.g., graduation, summer vacation, dropped out):

Did the client successfully complete the CURRENT term or course? ◯ **Yes** ◯ **No** ◯ **N/A**

Did the client successfully complete a degree or training program? ◯ **Yes** ◯ **No**

If the client is in some way BEGINNING school or training:

Will the client formally enroll in a new class / course? ◯ **Yes** ◯ **No** ◯ **N/A**

Will the client be enrolled in a program with a goal beyond the completion of this particular class / course or term? ◯ **Yes** ◯ **No** ◯ **N/A**

Does one of the client's CURRENT recovery goals include any kind of education, AT THIS TIME? ◯ **Yes** ◯ **No**

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DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

(skip this section if there are no changes)

CURRENT EMPLOYMENT If there are any changes to the client's employment, indicate ALL NEW and ONGOING statuses, including those previously reported.	Average Number of Hours per Week	Average Hourly Wage
Competitive Employment Paid employment in the community in a position that is also open to individuals without disability.		
Supportive Employment Competitive Employment (see above) with ongoing on-site or off-site job related support services provided.		
Transitional Employment / Enclave Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.		
Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business) Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) Program within an agency provides exposure to the standard expectations and advantages of employment. An Agency- Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.		
Non-paid (Volunteer) Work Experience Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.		
Other Gainful / Employment Activity Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and/or workshops providing instruction on issues pertinent to getting a job. (Does NOT include such activities as panhandling or illegal activities such as prostitution).		

Date of Employment Change: ______

Is the client unemployed AT THIS TIME? ◯ Yes ◯ No

Does one of the client's CURRENT recovery goals include any kind of employment AT THIS TIME? ◯ Yes ◯ No

If UNEMPLOYED: Why did the client change his/her employment status? **(check all that apply)**

- ☐ Attending school
- ☐ Retired
- ☐ Physical health condition
- ☐ Does not want to work
- ☐ Benefits or income is lost if money is earned
- ☐ Not satisfied with working conditions
- ☐ Transportation issues
- ☐ Domestic circumstances
- ☐ Military service
- ☐ Disciplinary actions
- ☐ Laid off
- ☐ Other

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PHYSICAL HEALTH

(skip this section if there are no changes)

Has there been a change in status?	CURRENT (select one for each question)	DATE
Client states that he/she is in good physical health?	◯ Yes ◯ No	
Client has access to needed medical services?	◯ Yes ◯ No	
Client receives needed medical services?	◯ Yes ◯ No	
Client has a primary care physician?	◯ Yes ◯ No	
Client uses a primary care physician?	◯ Yes ◯ No	
Client has access to needed dental services?	◯ Yes ◯ No	
Client receives needed dental services?	◯ Yes ◯ No	
Is the client obese (based on BMI)?	◯ Yes ◯ No	
Has the client EVER been told by a physician that he/she has diabetes?	◯ Yes ◯ No	

Did the client receive physical health services from a DHS clinic or hospital? ◯ Yes ◯ No

Does the client have a chronic physical health care problem or problems that require periodic medical services? ◯ Yes ◯ No

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CRISIS STABILIZATION / PMRT

(skip this section if there are no changes)

Did the client receive services in an Emergency Room or Crisis Stabilization? ◯ **Yes** ◯ **No**

Date of Service:

Indicate the type of Emergency Room / Crisis Stabilization intervention: **(select one)**

- ◯ ER - Physical Health
- ◯ ER - Psychiatric
- ◯ ER - Substance Abuse
- ◯ Crisis Stabilization - Psychiatric
- ◯ Crisis Stabilization - Substance Abuse

Was the client seen by a Psychiatric Mobile Response Team or 24/7 Response Team? ◯ **Yes** ◯ **No**

Did any of the Psychiatric Mobile Response Team or 24/7 Response Team calls result in a hospitalization? ◯ **Yes** ◯ **No**

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LEGAL

(skip this section if there are no changes)

JUSTICE SYSTEM INVOLVEMENT

Did the client have contact with the police?	Yes	No	
Was the contact related to mental health issues?	Yes	No	N/A
Was the contact related to substance abuse issues?	Yes	No	N/A
Has the client been arrested?	Yes	No	

Date of client's arrest: ______

How many were misdemeanor arrests? ______

How many were felony arrests? ______

Was the arrests related to a mental health issue?	Yes	No	N/A
Was the arrests related to a substance abuse issue?	Yes	No	N/A
Was the client incarcerated?	Yes	No	
Was the client placed on probation?	Yes	No	If yes, provide date: ______
Was the client removed from probation?	Yes	No	If yes, provide date: ______

CHANGE OF CONSERVATORSHIP STATUS

Has the client been placed on conservatorship?	Yes	No	Date of Conservatoship Status Change: ______
Has the client been removed from conservatorship?	Yes	No	

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