COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Older Adult Key Event Change (KEC)

Age Group: 60+

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:

Date of Program Name Change:

New Program Name (select one)

- ◯ FSP-Adult
- ◯ 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

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.

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Older Adult Key Event Change (KEC)

Age Group: 60+

ADMINISTRATIVE INFORMATION

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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

Name _____ IS# _____

Agency _____ Provider # _____

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)
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

Why did client change residential status?

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17) Physical Abuse
18) Sexual Abuse
19) Unable to maintain level of independence

Name _____ IS# _____

Agency _____ Provider # _____

OUTCOMES MEASURES APPLICATION FORM - OLDER ADULT KEC

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)
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)
2) At risk, sibling abuse
3) Caretaker / Absent or incapacitated
4) Decrease functioning
5) Decrease in financial status
6) Desired increase independence
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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

Is the client at risk of being removed from their CURRENT living arrangement?	◯ Yes	◯ No
Is the client's CURRENT living arrangement suitable? (According to clinician / FSP Team)	◯ Yes	◯ No
Is the CURRENT living arrangement in the least restrictive setting? (According to clinician / FSP Team)	◯ Yes	◯ No
Is the client satisfied with CURRENT living arrangement?	◯ Yes	◯ No
Have there been Suspected Dependent Adult Abuse reports made related to living arrangements?	◯ Yes	◯ No
Have there been incidents of violence related to living arrangments?	◯ Yes	◯ No

Name _____ IS# _____

Agency _____ Provider # _____

OUTCOMES MEASURES APPLICATION FORM - OLDER ADULT KEC

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Older Adult Key Event Change (KEC)

Age Group: 60+

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 #)

SOCIAL SUPPORT

(skip this section if there are no changes)

IDENTIFY CURRENT STATUS

Socializes with others	Yes	No		
Receives spiritual support	Yes	No		
Develops and maintains friendships	Yes	No		
Requires protection from abuse	Yes	No		
Client has age appropriate, positive peer relationships?	Yes	No		
Client has age appropriate involvement in family?	Yes	No	N/A	
Client has supportive interactions / relationships with:				
Parent	Yes	No	N/A	
Family	Yes	No	N/A	
Caregiver	Yes	No	N/A	
Is the family or significant other(s) involved in the client's treatment?	Yes	No		
Client has access to at least one stable, supportive adult?	Yes	No		

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Older Adult Key Event Change (KEC)

Age Group: 60+

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
- ☐ Medicare
- ☐ Veteran's Assistance (VA) Benefits
- ☐ Recipient of CalWORKs or TANF
- ☐ Private Insurance
- ☐ 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: _____

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

Older Adult Key Event Change (KEC)

Age Group: 60+

ADMINISTRATIVE INFORMATION

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DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL

(skip this section if there are no changes)

IDENTIFY CURRENT STATUS (select all that apply)

- ☐ Adult Day Health Care
- ☐ Senior Center Participation

GRADE LEVEL INFORMATION

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

◯ Day Care	◯ 6th Grade	◯ High School Diploma / GED
◯ Preschool	◯ 7th Grade	◯ Some College / Some Technical or Vocational Training
◯ Kindergarten	◯ 8th Grade	◯ Associate's Degree (e.g., A.A., A.S.) / Technical or Vocational Degree
◯ 1st Grade	◯ 9th Grade	◯ Bachelor's Degree (e.g., B.A., B.S.)
◯ 2nd Grade	◯ 10th Grade	◯ Master's Degree (e.g., M.A., M.S.)
◯ 3rd Grade	◯ 11th Grade	◯ Doctoral Degree (e.g., M.D., Ph.D.)
◯ 4th Grade	◯ 12th Grade	◯ Level Unknown (e.g., client in non-public school)
◯ 5th Grade	◯ GED Coursework	

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	☐ Technical / Vocational School	☐ Graduate School
☐ High School / Adult Education	☐ Community College / 4 year College	☐ Other

Date of Educational Setting Change: _____

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

Name _____ IS# _____

Agency _____ Provider # _____

Los Angeles County - Department of Mental Health

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL *continued*

(skip this section if there are no changes)

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	

Name _____ IS# _____

Agency _____ Provider # _____

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
OUTCOMES MEASURES APPLICATION
Older Adult Key Event Change (KEC)
Age Group: 60+

ADMINISTRATIVE INFORMATION

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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

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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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	
Client demonstrates signs of regressive behavior (bed wedding, soiling)?	◯ Yes ◯ No	
Client has violent encounters? Client demonstrates self-injurious behavior?	◯ Yes ◯ No	
Client has violent encounters?	◯ Yes ◯ No	
Client has a caretaker relationship?	◯ Yes ◯ No	
Is the caretaker a paid In-Home Worker?	◯ Yes ◯ No	
Is the caretaker a paid Supprted Transitional Worker?	◯ Yes ◯ No	
Is the caretaker a significant other?	◯ Yes ◯ No	
Is the caretaker a family member?	◯ 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	

Name ____ IS# ____

Agency ____ Provider # ____

Los Angeles County - Department of Mental Health

PHYSICAL HEALTH *continued*

(skip this section if there are no changes)

Based on the Mini Mental Status Exam (MMSE), the client presented with symptoms of cognitive impairment? ◯ Yes ◯ No

If yes, what level? **(select one)**

- ◯ Mild
- ◯ Moderate
- ◯ Severe

Based on the Confusion Assessment Method (CAM) the client presented with symptoms of delirium? ◯ Yes ◯ No

If yes, identify the most appropriate: **(select one)**

- ◯ Acute Change
- ◯ Altered Level of Consciousness
- ◯ Disorganized Thinking
- ◯ Inattention

Based on the Geriatric Depression Scale (GDS), the client presented with depressive Symptoms? ◯ 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

Name _____ IS# _____

Agency _____ Provider # _____

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

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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**

Name | IS#

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Los Angeles County - Department of Mental Health

Form MH #692
Rev. 6/30/2016

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OUTCOMES MEASURES APPLICATION

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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		
Does the client have a Probate Conservator?	Yes	No	Date of Probate Conservator Status Change:	
Has the client been removed from Probate Conservator?	Yes	No		
Does the client have a Power of Attorney?	Yes	No	Date of Power of Attorney Status Change:	
Does the client no longer have a Power of Attorney?	Yes	No		

Name ____ IS# ____

Agency ____ Provider # ____