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** ☐☐☐☐

Client L. Name _____ **Client F. Name** _____

Partnership Date _____ **Assessment Date** _____

Partnership Service Coordinator (Last Name) _____ **Assessment Completed By** ☐☐☐☐☐☐☐

CHANGE IN ADMINISTRATIVE INFORMATION

(skip this section if there are no changes)

New Provider Number ☐☐☐☐ Date of Provider Number change: _____

New Partnership Service Coordinator (Last Name) _____ Date of Partnership Service Coordinator Change: _____

New FSP Program Name (check one): ☐ FSP-Adult ☐ FSP-Older Adult

Date of FSP Program Change: _____

In which program(s) is the client CURRENTLY involved?

AB2034

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

Date of AB2034 Change: _____

Governor's Homeless Initiative (GHI)

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

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

MHSA Housing Program

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

Date of MHSA Housing Program Change: _____

Indicate New Partnership Status:

☐ Discontinuation / Interruption of Full Service Partnership and/or community services / program **(Indicate reason below)**
☐ Reestablishment of Full Service Partnership and/or community services / program

Date of Partnership Status Change: _____

If there is a DISCONTINUATION / INTERRUPTION of Full Service Partnership and/or community services / program, indicate the reason (check 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 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.

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 a 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? (circle one for each selection)
	GENERAL LIVING ARRANGEMENT				
☐	With adult family members other than parents				YES NO UNKNOWN N/A
☐	In an apartment of house alone or with spouse / partner / minor children / other dependents / roommate - must hold lease or share in rent / mortgage				YES NO UNKNOWN N/A
☐	With one or both Biological / Adoptive Parents				YES NO UNKNOWN N/A
☐	Single Room Occupancy (SRO) (must hold lease)				YES NO UNKNOWN N/A
	SHELTER / HOMELESS				
☐	Emergency Shelter				YES NO UNKNOWN N/A
☐	Homeless (includes people living in their cars)				YES NO UNKNOWN N/A
☐	Temporary Housing (includes people living with friends but paying no rent)				YES NO UNKNOWN N/A
	HOSPITAL				
☐	Acute Medical Hospital				YES NO UNKNOWN N/A
☐	Acute Psychiatric Hospital / Psychiatric Health Facility (PHF)				YES NO UNKNOWN N/A
☐	State Psychiatric Hospital				YES NO UNKNOWN N/A
	RESIDENTIAL PROGRAM				
☐	Alcohol or Substance Abuse Residential Rehabilitation Center				YES NO UNKNOWN N/A
☐	Crisis Residential Program				YES NO UNKNOWN N/A
☐	Group Living Home				YES NO UNKNOWN N/A
☐	Institution for Mental Disease (IMD)				YES NO UNKNOWN N/A
☐	Long Term Residential Program				YES NO UNKNOWN N/A
☐	Mental Health Rehabilitation Center (MHRC)				YES NO UNKNOWN N/A
☐	Skilled Nursing Facility (physical)				YES NO UNKNOWN N/A
☐	Skilled Nursing Facility (psychiatric)				YES NO UNKNOWN N/A
☐	Transitional Residential Program				YES NO UNKNOWN N/A
	JUSTICE PLACEMENT				
☐	Jail				YES NO UNKNOWN N/A
☐	Prison				YES NO UNKNOWN N/A
	SUPERVISED PLACEMENT				
☐	Assisted Living Facility				YES NO UNKNOWN N/A
☐	Licensed Community Care Facility (Board and Care)				YES NO UNKNOWN N/A
☐	Sober Living Home				YES NO UNKNOWN N/A
☐	Unlicensed but supervised individual placement (includes paid caretakers, personal care attendants, etc.)				YES NO UNKNOWN N/A
	OTHERS				
☐	Other				YES NO UNKNOWN N/A
☐	Unknown				YES NO UNKNOWN N/A

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

LIVING ARRANGEMENTS *continued*
(skip this section if there are no changes)

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

SOCIAL SUPPORT
(skip this section if there are no changes)

IDENTIFY CURRENT STATUS

Socializes with others	YES	NO	(circle one)	
Develops and maintains friendships	YES	NO	(circle one)	
Receives spiritual support	YES	NO	(circle one)	
Requires protection from abuse	YES	NO	(circle one)	

Client has age appropriate, positive peer relationships?	YES	NO	UNKNOWN		(circle one)
Client has age appropriate involvement in family?	YES	NO	UNKNOWN	N/A	(circle one)
Client has supportive interactions / relationships with:					
Parent	YES	NO	UNKNOWN	N/A	(circle one)
Family	YES	NO	UNKNOWN	N/A	(circle one)
Caregiver	YES	NO	UNKNOWN	N/A	(circle one)
Is the family or significant other(s) involved in the client's treatment?	YES	NO	UNKNOWN		(circle one)
Client has access to at least one stable, supportive adult?	YES	NO	UNKNOWN		(circle one)

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
- ☐ Participant in CalWORKs
- ☐ Private Insurance
- ☐ HMO

CHANGE IN PAYEE STATUS

Has the client been placed on Payee status?	YES	NO	UNKNOWN	(circle one)
Has the client been removed from Payee status?	YES	NO	UNKNOWN	(circle one)

Date of Payee Status Change: _____

DAILY ACTIVITIES / VOCATIONAL / EDUCATIONAL LEVEL

(skip this section if there are no changes)

IDENTIFY CURRENT STATUS

Adult Day Health Care **YES NO (circle one)**

Senior Center Participation **YES NO (circle one)**

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 UNKNOWN N/A (circle one)**

Did the client successfully complete a degree or training program? **YES NO UNKNOWN (circle one)**

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

Will the client formally enroll in a new class / course? **YES NO UNKNOWN N/A (circle one)**

Will the client be enrolled in a program with a goal beyond the completion of this particular class / course or term? **YES NO UNKNOWN N/A (circle one)**

Does one of the client's CURRENT recovery goals include any kind of education, AT THIS TIME? **YES NO UNKNOWN (circle one)**

GRADE LEVEL OF COMPLETION

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

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

Date of Grade Level Completion: _____

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	Hourly Wage
Competitive Employment Paid employment in the community in a position that is also open to individuals without disability		
Supported 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 Status Change**:**

Is the client unemployed AT THIS TIME? **YES NO UNKNOWN** (**circle one**)

Does one of the client's CURRENT recovery goals include any kind of employment AT THIS TIME ? **YES NO UNKNOWN** (**circle one**)

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

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

PHYSICAL HEALTH

(skip this section if there are no changes)

Has there been a change in status?	**CURRENT** (**circle one for each question**)	**DATE**
Client states that he/she is in good physical health?	**YES NO UNKNOWN**	
Client has access to needed medical services?	**YES NO UNKNOWN**	
Client receives needed medical services?	**YES NO UNKNOWN**	
Client has a primary care physician?	**YES NO UNKNOWN**	
Client uses a primary care physician?	**YES NO UNKNOWN**	
Client has access to needed dental services?	**YES NO UNKNOWN**	
Client receives needed dental services?	**YES NO UNKNOWN**	

PHYSICAL HEALTH *continued*
(skip this section if there are no changes)

	CURRENT (circle one for each question)	DATE
Client demonstrates signs of regressive behavior (bed wetting, soiling)?	YES NO UNKNOWN	
Client demonstrates self-injurious behavior?	YES NO UNKNOWN	
Client has violent encounters?	YES NO UNKNOWN	
Client has a caretaker relationship?	YES NO UNKNOWN	
Is the caretaker a paid In-Home Worker?	YES NO UNKNOWN	
Is the caretaker a paid Supported Transitional Worker?	YES NO UNKNOWN	
Is the caretaker a significant other?	YES NO UNKNOWN	
Is the caretaker a family member?	YES NO UNKNOWN	
Is the client obese (based on BMI)?	YES NO UNKNOWN	
Has the client EVER been told by a physician that he/she has diabetes?	YES NO UNKNOWN	

Based on the Mini Mental Status Exam (MMSE), the client presented with symptoms of cognitive impairment. **YES NO UNKNOWN (circle one)**

If yes, what level: **(check one)**

☐ Mild ☐ Moderate ☐ Severe

Based on the Confusion Assessment Method (CAM), the client presented with symptoms of delirium. **YES NO UNKNOWN (circle one)**

If yes, identify the most appropriate: **(check 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 UNKNOWN (circle one)**

Did the client receive physical health services from a DHS clinic or hospital? **YES NO UNKNOWN (circle one)**

Does the client have a chronic physical health care problem or problems that require periodic medical services? **YES NO UNKNOWN (circle one)**

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 UNKNOWN (circle one)**

Date of Service**:** _____

Indicate the type of Emergency Room / Crisis Stabilization intervention: **(check 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 UNKNOWN (circle one)** How many times? _____

Did any of the Psychiatric Mobile Response Team or 24/7 Response Team calls result in a hospitalization? **YES NO UNKNOWN (circle one)** How many times? _____

LEGAL

(skip this section if there are no changes)

JUSTICE SYSTEM INVOLVEMENT

Did the client have contact with the police? **YES NO UNKNOWN** (circle one)

Was the contact related to mental health issues? **YES NO UNKNOWN N/A** (circle one)

Was the contact related to substance abuse issues? **YES NO UNKNOWN N/A** (circle one)

Has the client been arrested? **YES NO UNKNOWN N/A** (circle one)

Date of client's arrest: _____

How many were misdemeanor arrests? _____ How many were felony arrests? _____

Was the arrest related to a mental health issue? **YES NO UNKNOWN N/A** (circle one)

Was the arrest related to a substance abuse issue? **YES NO UNKNOWN N/A** (circle one)

Was the client incarcerated? **YES NO UNKNOWN** (circle one)

Was the client placed on probation? **YES NO UNKNOWN** (circle one)

-If yes, provide date: _____

Was the client removed from probation? **YES NO UNKNOWN** (circle one)

-If yes, provide date: _____

CHANGE OF CONSERVATORSHIP STATUS

Has the client been placed on conservatorship? **YES NO UNKNOWN** (circle one)

Has the client been removed from conservatorship? **YES NO UNKNOWN** (circle one)

Date of Conservatorship Status Change: _____

Does the client have a Probate Conservator? **YES NO UNKNOWN** (circle one)

Has the client been removed from Probate Conservator? **YES NO UNKNOWN** (circle one)

Date of Probate Conservator Status Change: _____

Does the client have a Power of Attorney? **YES NO UNKNOWN** (circle one)

Does the client no longer have a Power of Attorney? **YES NO UNKNOWN** (circle one)

Date of Power of Attorney Status Change: _____