Rapid Resource for Families | IAFT®

IAFT® Program Description

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Intensive Alternative Family Treatment (IAFT®) is a specialized family-type, treatment foster care service provided to children/youth and their families in a community setting. Individuals needing this level of care often present with challenging behaviors; are at risk for out-of-home placement; will benefit from clinically focused treatment to avoid placement in a higher level of care; and/or make a planned transition from a more restrictive setting. IAFT® strives to provide a home environment for healing to take place. The desired outcome is to exhibit improved individual and family functioning upon successful return to a natural living home/least restrictive setting after treatment.

IAFT® provides a trauma-informed, structured, therapeutic, and supervised home environment to ameliorate behaviors and improve the level of functioning for children/youth and their families and/or natural supports. IAFT® Agencies track data to inform treatment delivery and show clinical process outcomes during treatment and upon discharge. Through Continuous Quality Improvement activities, quarterly data and outcomes monitoring, and quarterly compliance and fidelity reviews, fidelity to the model is monitored by Rapid Resource for Families. The fourteen (14) elements of IAFT® are designed to provide intensive therapeutic services/supports to improve the individual's mental/behavioral health and prevent further decompensation once returned to the family or stepped down to a lower level of care.

- **Intensive:** Treatment at this level is highly supervised through ongoing clinical and administrative supervision from an IAFT® Provider Agency that occurs daily with professional staff, and weekly in-person for the IAFT® parent(s), staff, and supervisor. IAFT® includes a team of professionals, embracing a System of Care philosophy. They provide a team approach to care and treatment for children/youth and their families to encourage clinical growth and improve individual/family functioning.
- **Alternative:** IAFT® is provided to children/youth with the hope of diverting from higher levels of care or transitioning from restrictive placements. Individuals meeting entrance criteria for IAFT® have presenting clinical needs that are difficult to place or require special treatment needs that can be better addressed with the one-on-one therapeutic services in an IAFT® home.
- **Family:** IAFT® is family focused throughout the course of treatment. Family or other designated natural supports are heavily involved from the point of referral, admission processes, matching of the IAFT® home, and discharge planning. Shared parenting is highly recommended between the parent(s)-family of permanency and the IAFT® treatment team to ensure that transference of shared treatment goals and behavioral interventions. This will ensure long-lasting recovery and a successful transition to home or a lower level of care.
- **Treatment**: Children/youth and their families who receive IAFT® should see symptom reduction and improved interactions with others as treatment progresses, ideally over a 9 to 12-month period. IAFT® is goal oriented and is guided by the Person-Centered Plan (PCP) of the children/youth and their families. Clinical outcome measures are continuously tracked; data is gathered to inform ongoing treatment needs and is also followed post-discharge to ensure treatment gains are continued following the service. Weekly therapy is provided by a licensed/provisionally licensed therapist to the child/youth and/or family, to focus on treatment goals and work to improve functioning impairments as documented on the

Comprehensive Clinical Assessment (CCA) and PCP. Treatment duration will depend heavily on individual needs and permanency planning. It is incumbent on the IAFT® Provider Agency to document ongoing medical necessity for the service and request concurrent authorization through the LME/MCO/CFSP.

IAFT® can only be provided by a Rapid Resource for Families (RRFF) approved Network Provider Agency with the oversight of RRFF. Upon receipt of an MCO letter of recommendation, an IAFT® Network Provider agency will undergo a credentialing process through RRFF. If approved, the request will go to the RRFF Board for final disposition for acceptance into the Network. IAFT® is covered under the EPSDT Special Provision and the 42 U.S.C. §1396d(r) [1905(r)of the Social Security Act] therefore Provider Agencies must complete and submit a completed an EPSDT request before admission and annually thereafter.

Trauma-Informed Approach to IAFT®

Rapid Resource for Families and the Intensive Alternative Family Treatment® model strives to provide a treatment context in which healing takes place for those youth and families who have experienced trauma of any kind. The IAFT® Network endeavors to support and implement the SAMSHA (US Department of Health and Human Services, 2012) concept of a trauma-informed approach grounded in four assumptions and six key principles.

Trauma-Informed Assumptions with the IAFT® Model

- IAFT® **realizes** the widespread impact of trauma and understands the potential paths for wellness, resilience, and recovery.
- IAFT® **recognizes** the many symptoms, signs, and triggers of trauma in youth and families, communities, and circles of support. The Adverse Childhood Experience (ACE) Questionnaire is administered following admission to gain knowledge regarding exposure to adverse life events and guide trauma treatment interventions.
- IAFT® **responds** to the wide body of research, science, and knowledge regarding trauma and the need for healing by developing and implementing policies and procedures for trauma-informed treatment-based practices.
- IAFT® **resists and manages re-traumatization** by planned and purposeful matching of youth/families to treatment homes/parent(s); constant supervision and staffing to maintain placement stability and reduce moves to new homes or disruption. Additionally, through weekly in-person supervision* secondary or vicarious trauma of IAFT® Treatment Parents/Staff is attended to and addressed through self-care.

Trauma-Informed Principles Integrated into IAFT®

1. **Safety:** IAFT® Treatment Parent(s), along with IAFT® Staff, work to provide a physically and psychologically safe home environment and relationships to promote healing and resilience. Through Person-Centered Planning, comprehensive crisis plans, and feedback from youth and families, individual definitions of safety are sought, explored, and implemented as a priority.
2. **Trustworthiness and Transparency:** IAFT® Network Agencies and Rapid Resource for Families strive to maintain a professional relationship built on the goal of building and maintaining trust and transparency with the expectation to model fidelity and continuous quality improvement activities and purposes. Additionally, IAFT® Staff and Agencies are encouraged to deliver

admission/discharge procedures, treatment interventions, and day-to-day interactions with team members, youth and families equally grounded in trust and openness.

3. **Shared Experiences through Peer Support Opportunities:** When possible and clinically appropriate, IAFT® Agencies are encouraged to seek out "peers" or "families with similar shared experiences" to provide support, advocacy, and enhanced collaboration in promoting recovery and healing.
4. **Collaboration and Mutual Goals:** At the center of the IAFT® model is teamwork. The IAFT® model seeks to empower all team members and supports, especially Treatment Parents, to be an Agent of Change for the youth and families. Through weekly in-person supervision, * daily phone calls/consultation, and Child and Family Team Meetings, partnerships and true collaboration towards desired outcomes are reinforced. Every member of the team has a role to play in the specific trauma-informed approach guiding treatment outcomes.
5. **Empowerment, Voice, and Choice:** Taking a Person-Centered approach to treatment, the voice of youth and families are sought, attended to, supported, and built upon as recovery is gained and resiliency strengthened. Weekly IAFT® Parent and Team Supervision also allows the voices of individual members to be heard and fully incorporated into treatment approaches and discharge/transition planning.
6. **Cultural, Historical, and Gender Issues:** IAFT® Network Agencies are encouraged to leverage the healing value of traditional cultural connections, incorporate polices and processes that are responsive to the racial, ethnic, and cultural needs of youth and families, and recognize and address historical or intergenerational trauma. (Department of Health and Human Services, 2014)

Service Location

IAFT® is to be provided in a licensed Therapeutic Family Foster Home approved by the N.C. Department of Health and Human Services, Division of Social Services (Licensing Authority). In addition to remaining in full compliance with the IAFT® Elements, the IAFT® homes will adhere to additional rules and regulations as outlined in applicable therapeutic foster care licensure rules.

Staffing Requirements

IAFT® Provider Agencies are permitted to establish their specific team composition and titles for the designated roles. At a minimum, the team roles must consist of:

Team Member	Requirements	Primary Characteristics and Markers for Quality & Fidelity
IAFT® Treatment Parent(s)	Licensed for TFC-Family Type	• Increased training is provided to Treatment Parent(s) and is on file (in CCW). • Are often highly skilled at addressing higher-level behaviors via professional parenting strategies and through a trauma-lens. • Engage in shared parenting and seek out partnerships with the family of permanence. • Communicate daily (minimum 5 days a week) with the IAFT® Coordinator for coaching, problem-solving, and detailed behavior monitoring, and provide higher quality documentation based on the treatment/training model of the agency. • Are motivated to provide positive outcomes in youth and goal achievement. • Utilizes respite to manage stress and prevent burnout.

IAFT® Coordinator (Case Manager, Consultant, Coach, etc.)	Qualified Professional Status	• Driven by teamwork and open communication with all IAFT® team members and support for the youth/family. • Able to coordinate care for a caseload of 8-10 youth with quality and fidelity. • Utilizes daily check-ins/phone calls with Treatment Parent(s) to stay ahead of behaviors, promote placement stability, and ensure positive outcomes. • Delivers effective weekly supervision and crisis response, and completes concise, quality documentation. • Collaborates with peers during Weekly Team Supervision with goal of placement stability and positive treatment outcomes. • Demonstrates strong clinical understanding of trauma/behaviors.
IAFT® Therapist	A Licensed Professional, currently licensed in NC (*i.e., LPA, LPC, LMFT, LCSW, as well as associate level licensed professionals)*	• Dedicated to IAFT® caseload within Agency: cannot fulfill a clinical role on another Team service (i.e., IIH, Day Treatment, FCT, MST). This allows for scheduling flexibility within the assigned caseload to see each IAFT® youth weekly if needed for no-shows, cancellations, make-up and/or crisis response. IAFT® Therapists ideally should carry a caseload of 10-14 youth/families. • Driven by teamwork & collaboration as a fully integrated IAFT® Team member, participates in weekly IAFT® Team staffing, supervision, and monthly Child & Family Team meetings. • Skilled at treatment planning, clinical documentation, and a variety of treatment models. Assess for trauma, demonstrate diagnostic competence and awareness of biopsychosocial framework of whole person health and wellness. • Guides team skill building for youth, treatment family, and family of permanence. • Provides, at minimum, weekly therapy (individual/family) or more as needed with youth/family of permanence. At least once a month convenes conjoint family therapy sessions with youth & Treatment Parent(s). • Ability to respond to crises in partnership with IAFT® Team to guide de-escalation interventions, safety planning, and participate in crisis debriefing. Follow up on incident reporting, updating crisis plans, and any other clinical/administrative documentation. • Weekly sessions focused on symptom reduction, behavior change, trauma resolution, health patterns of communication, and relationship building. • Delivers treatment interventions focused on improving quality of life through remediation of ACE Scores/Social Determinants of Health-Unmet Needs in a systems approach aimed at permanency and/or success in the least restrictive setting. • Able to receive feedback from the IAFT® team, youth, and family of permanence and pivot as needed in treatment planning to ensure successful outcomes and appropriate discharge planning. • During Weekly IAFT® Team Staffing, work with Team Supervisor to guide weekly treatment recommendations in response to presenting behaviors and trauma resolutions/triggers. Utilizes creativity and clinical knowledge/skills to remain proactive in treatment approaches within the treatment milieu and treatment home/family of permanence.
IAFT® Supervisor	Qualified Professional Status	• Provides dyadic weekly supervision, focused on permanency, treatment regression, and relevant recommendations. • Guides model fidelity of IAFT® delivery and treatment recommendations. • Ensures staff retention through effective support and collaboration, creative interventions aimed at placement stability.

		• Documents weekly team supervision with solid recommendations and follow-up activities as it occurs. • Blends training, coaching, and consultation into all activities and interactions with IAFT® team members to ensure quality of care and fidelity to the model.
Psychiatric Consultant	A Licensed Professional, currently licensed in NC *(Child and Adolescent Psychiatrist, Psychiatric Nurse Mental Health Nurse Practitioner, Physician Assistant)*	• Consults monthly with IAFT® team on caseload. • Provides clinical guidance to team on behaviors, medication interactions, and symptomology. • Collaborates on youth's whole health to improve quality of life.

Process: IAFT® Practice Elements-Purpose, Application, and Fidelity Markers

Based on available research[1], these (14) elements have been identified as the most crucial to effective services in the IAFT® settings. The validity of these practice elements and the synthesis of elements has been evaluated to determine if they indeed generate a positive impact and if combined delivery achieves better clinical outcomes for consumers and their families/communities.

*** Hybrid Model Implementation: Approval Requirements**

1. Agency must notify RRFF of desire to utilize the hybrid model and be prepared to note that Telehealth/Virtual platforms should adhere to privacy, HIPAA compliance standards for security, and best practices per clinician's licensing board, therapeutic model/milieu utilized, and follow the preferences of the youth, family, and/or treatment parent(s).
2. Following through with staff training requirements identified under Best Practices.
3. Follow documentation and staffing requirements as noted under Best Practices.
4. Agency must review its internal Telehealth policy with the IAFT® team prior to implementation.

1. **Outcomes Measured & Evaluated:** Clinical level outcomes for consumers and families, agency process outcomes are completed, tracked in the agency database (CCW), and analyzed for treatment indicators of progression, emerging needs, and overall agency fidelity.

Purpose	• Data-driven outcomes are an important structural component of the IAFT® program. Data-informed practice ensures treatment is being provided in a manner to rehabilitate and improve the functioning and symptomology of consumers/families. • Outcomes help prove the clinical effectiveness of the model as well as show trends and patterns for consumers (population) in which IAFT® is effective and those areas of the model/program that may need to be further evaluated for program improvement. • Agency Process outcomes and data monitoring help ensure fidelity to the IAFT® model and best practices across all IAFT® agencies.
Procedure	• Staff are trained in the CCW database and remain knowledgeable about outcome metrics. • Responsible staff complete outcome metrics promptly and on schedule for each IAFT® consumer from admission, fixed points during treatment, and upon discharge.
Fidelity Marker	• All outcome metrics are entered into CCW within (5) business days of occurrence. *Timelines and collection tools are followed as indicated in IAFT® Data Collection Protocols.* • Completion, accuracy, and timelines of outcome metrics are monitored during compliance reviews. • Approved waiver on file (in CCW) for exemption of Element for clearly stated administrative or technical reasons.
Best Practices	1. Utilize a calendar or other reminder system of due dates or reminders of CGAS metrics requiring 3-month intervals to ensure updates are done timely. For items such as EPSDT, keep an annual reminder as well to review the ongoing medical necessity for IAFT® treatment.

	2. For daily/weekly/monthly metrics (i.e., Attendance Calendar, Weekly Fidelity, Psychiatric Oversight) identify a workflow process either several times a week or within the 5-day rule as a guideline (to provide a cushion) to enter data in the database. IAFT® staff may be less likely to become overwhelmed if behavior tracking and weekly data metric requirements are worked into their daily workflow ahead of other occurrences happening such as crises or disruptions, which interfere with the daily work routine.

2. 1 IAFT® child per Treatment Family

Purpose	• Focused one-on-one interventions and purposeful day-to-day interaction between the IAFT® consumer and Treatment Parent(s) allow for heighted treatment and intensive management of behavior toward rehabilitation of presenting needs.
Procedure	• Agency staff evaluates IAFT® Treatment Parent(s) for matching consumer needs, skill level, and environmental preferences to allow for treatment success and admission into the home. • Approved waivers of 1+ youth in the treatment home will need to be documented in the PCP of the youth with guardian/CFT signatures indicating acknowledgement and approval.
Fidelity Marker	• Agency Placement Log and Residential Bedboard (in CCW) indicate only one child per licensed home. • Approved Waiver on file for exemption of Element for clearly stated *clinical reasons*.
Best Practices	• One child is the sole focus in the treatment home and occasionally deviates when there is a sibling set with an Element Waiver approved by RRFF. • Waivers for adding another youth in the home (receiving treatment) are to be requested ahead of time, and must be based on solid clinical rationale, clear safety guidelines, and risk evaluation of disruption potential for either youth.

3. Caseload of 8 to 10 children/youth per IAFT® Coordinator

Purpose	• Limited caseloads allow for deliberate organization of case management and care coordination activities between all Child & Family Team members involved in the consumer's care to facilitate the appropriate delivery of IAFT® services.
Procedure	• The agency reporting method of identified Coordinator caseload (average of 6-8). • Caseloads can be a mixture of FFC, TFC and IAFT® cases but cannot exceed 8-10 humans maximum.
Fidelity Marker	• The caseload verification form is completed and submitted to RRFF upon request and reflects the number of individuals assigned to the IAFT® Team member.
Best Practices	1. Keeping the caseload low allows extra support and attention to be given to the Treatment Parent(s) day-to-day and during times when the youth may be struggling with transitions, were just placed, having crises, dealing with medication issues, and other challenges that frequently arise given the population served. 2. Agency Leadership is encouraged to monitor caseload size both in number and severity of need for each individual. Fidelity to the Element is built on the goal of staff retention and burn-out prevention of valuable staff.

4. Youth Behavior Tracking: Daily phone/personal contact (M-F) between Treatment Parent(s) and staff with tracking a minimum of 5 days per week with data for all 7 days recorded in the RRFF CCW database.

Purpose	• Daily contact between IAFT® staff and Treatment Parent(s) enhances the level of support, on-the-spot problem solving, and ongoing evaluation of behaviors and interventions that are tied to target/problematic behaviors identified in the PCP. • Track and discuss the frequency of observed target behaviors throughout the week, evaluate the effectiveness of treatment parent intervention, and overall progression or regression of behavioral response and motivation to change. • Attend to stress level variations of IAFT® Treatment Parent(s) that might indicate additional supervision, training, and/or respite need. • Build and maintain rapport and support of the team through increased, purposeful, and productive communication. • Track incidents or efforts at Shared Parenting with the family of permanence and engagement with natural supports to support the transition/discharge plan.

Procedure	• The Provider Agency will define timelines and methods of daily contact (5) days a week between the Coordinator and Treatment Parent(s). Data for all (7) days will be entered into CCW and scoring for each targeted behavior will be entered once per week. • The Coordinator will provide support, guidance, and coaching to the Treatment Parent(s) and record data in CCW database.
Fidelity Marker	• Behavior data is entered into the CCW database for each week of treatment within (5) business days of the occurrence. • Documented observed behaviors, the effectiveness of interventions utilized, and overall stress level should match other forms of documentation for treatment clarity and consensus.
Best Practices	• Identify and set aside a dedicated time each workday to complete the corresponding data metrics from the previous day's check-in while the information and assessment are fresh and can be entered accurately. • Daily contact is meant to be a verbal conversation to support teamwork, connection, and supportive interactions. At times, due to crises or conflicting schedules, a text message, email, or other virtual contact is allowed, but it must be documented as the method of contact in the database. Live conversations assist in being able to gauge the Treatment Parent(s)' mindset and attitude as well as listening for signs of burnout/stress.

5. **Treatment Parent Supervision:** Weekly in-person* contact between IAFT® Treatment Parent(s) and IAFT® Staff

Purpose	• Effective supervision, both clinical and administrative, is integral to the adherence to IAFT® fidelity. • As a foundation of the IAFT® treatment model, the purpose of weekly supervision with the IAFT® parent(s) is the improvement of quality of practice to improve outcomes for children and families. • Supervision should provide a safe and reliable space to build and maintain mutual trust and respect, and reflect on treatment, behaviors, and shared decision-making. • Weekly sessions should also include a mixture of one-on-one training regarding a variety of topics to improve treatment parent skill level and provide individualized treatment for the consumer. • Behavioral data tracked should be reviewed to monitor behavior change, youth motivation, and any specific interventions needed to elicit desired behavioral outcomes. • Address any secondary or vicarious trauma that might be impacting the IAFT® Treatment Parent(s) or bio-children in the home.
Procedure	• Documentation of supervision via a note reflective of training areas needed by IAFT® Treatment Parent(s) to address individualized clinical needs of the consumer and/or implementation of agency treatment/training model.
Fidelity Marker	• Documentation of weekly supervision sessions with designated duration, location, and parties present. 60% of the Treatment Parent Supervision will be in-person in the IAFT® home at least one hour in duration each week. * • Concise documentation of session content, identified training needs, recommendations, and follow-up.
Best Practices	1. IAFT® strives to exceed state mandates with more contact, personal attention, and individualized team support tailored to the needs of the youth and Treatment Parent(s), this ideally should be reflected in the documentation. 2. Clinical supervision activities instruct, model, and encourage self-reflection of the supervisee's acquisition of clinical and administrative skills through observation, evaluation, and mutual problem-solving. Effective, open, and solid supervision helps to ensure staff retention (all levels) and burnout prevention and thus supports a quality treatment environment for the youth and family. * **Hybrid Model Requirements*:*** 1) IAFT® Weekly Treatment Parent Supervision: IAFT® Coordinator may incorporate virtual sessions into service delivery for Treatment Parent(s) weekly supervision as long as 60% or more of supervisions visits are in-person in the home. Supervision must be in-person during the weeks that the therapist utilizes a virtual session. 2) IAFT® Coordinator will ensure the CCW Weekly Fidelity data reflects face-to-face as in-person or virtual visits on the day supervision is provided.

	3) Youth being served using the Hybrid Model will be identified on the Caseload Verification Form.

6. IAFT® Team Supervision: Weekly Face-to-Face Contact between IAFT® Staff and Supervisor(s)

Purpose	• Effective group/team supervision, reflective of both clinical and administrative, is integral to the adherence to IAFT® fidelity. Equally important is teamwork and communication among team members. • A designated time is provided for the team to review the current IAFT® caseload in a planned and purposeful manner. • Address any secondary or vicarious trauma that might be impacting the IAFT® team members.
Procedure	• Supervision that is focused on proactive work being accomplished through review of behavior checklists, clinical supervision regarding treatment parent interactions with the consumer, rating treatment progress, training needs, and changes needed in treatment planning. • Weekly Team Supervision can occur in-person or by virtual means (confidential software platform). Documentation of the method of the meeting must be included in the documentation as well as all team members present.
Fidelity Marker	• Documentation of weekly supervision with IAFT® team members reflecting review of treatment and consumer needs; Treatment Parent(s) training needs; discharge/transition planning; addressing barriers to treatment or Element implementation; recommendations addressing short-term and/or long-term goals and/or other issues as identified by the team. • Documentation of weekly efforts, plan of action for the coming week (timeframe), and documented follow-up or results from the prior week's supervision recommendation(s).
Best Practices	• Each member of the IAFT® team has a different relationship with the youth and Treatment Parent(s) and this is an opportunity to bring the events of the week together. Sharing what each team member knows from their perspective is a way to identify potential crises or disruptions and get ahead of them to ensure placement stability and clinically driven treatment interventions. • Clinical supervision activities instruct, model, and encourage self-reflection of the supervisee's acquisition of clinical and administrative skills through observation, evaluation, feedback, and mutual problem-solving. Effective, open, and solid supervision helps to ensure staff retention (all levels) and burnout prevention and thus supports a quality treatment environment for the youth and family. • The IAFT® supervisor's responsibilities for best practices: provide support, consultation, and oversight of youth's treatment to include assessment of needs; behavioral interventions reflective of current diagnoses; sound clinical reasoning and case formulation which addresses documentation; treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions. At best, documentation of IAFT® team supervision includes an ongoing review of the youth's treatment success and challenges; permanency efforts and challenges; discharge planning activities and identified benchmarks to reflect treatment progress. As safety issues arise or ethical concerns arise, the weekly team format can provide solution-focused ideas to mitigate concerns. ***Hybrid Model Requirements:** 1) Agency must identify safeguards to ensure that the youth's needs are being met and are aware that not all youth respond favorably to telehealth. Youth receiving hybrid therapy must be noted during Weekly Team Supervision and confirm how the youth is responding.

7. 24/7 Crisis Support

Purpose	• Proactive crisis planning, response, and prevention are integral to addressing challenging behaviors while providing the youth with a safe and supervised opportunity to use new skills and coping strategies. • Crisis supports operate on known predictive behaviors, trauma triggers, past successful interventions, and response strategies for the consumer and his/her supports. Accurate information such as contacts, medication, and diagnoses are to be routinely updated on the Crisis Plan.

Procedure	• The agency is to have identified 24/7 crisis response protocols and responsible IAFT® trained personnel. Agencies must adhere to current regulations and/or rules surrounding crisis response protocols. This can include but is not limited to the following examples: 1. IAFT® staff must assess youth in crisis telephonically in combination with Treatment Parent(s) or another support person to ascertain the nature of the crisis episode, de-escalation steps, and response needed. 2. Risk assessment should be conducted to determine if a face-to-face response is required. During the assessment of risk or safety needs, IAFT® staff must consider all other alternatives to hospitalization, such as emergency therapy sessions; in-person debriefing and de-escalation interventions; psychiatric consultation or medication adjustments; safety planning in the home/community; use of respite or other community resources. • Consumer Crisis Plan is to be updated as changes are made, new information is learned, and identifies roles, responsibilities, and contacts. Updated crisis plans are uploaded into the CCW database.
Fidelity Marker	• Crisis Plan which identifies accurate information, proactive interventions matched to consumer needs, and First Responder contacts. • Crisis Incidents are reviewed during Psychiatric Oversight. Date of incident, debriefing, and report to RRFF are noted on the Psychiatric Oversight form in CCW.
Best Practices	• The team should debrief the incident together and identify new strategies for prevention with updated crisis plan interventions. Review and complete an incident report and report to regulatory, licensing bodies, and RRFF as needed. • During a crisis episode, if not able to de-escalate over the phone, IAFT® team member(s) should respond to the crisis in person. The responder should be an IAFT® member who has an already established relationship with the child; the child may be more likely to respond to that team member positively. If crisis rotation occurs with non-IAFT® trained staff; there should be familiarity with the crisis plan of all IAFT® clients. • IAFT® agencies must maintain appropriate after-hours and emergency coverage and respond in a timely and appropriate manner to the youth and Treatment Parent's needs. Calling 911 should not be the first line of contact for a behavioral health issue unless the emergency is life – threatening.

8. Psychiatric Oversight and Consultation at a minimum of once every 30 days documented in CCW

Purpose	• Clinical Oversight by Psychiatric Staff to review and coordinate the overall clinical direction of treatment and determine with team members any other needed support, services, or recommendations. • A team approach to assess therapeutic interventions and support to achieve consumer/family outcomes and discharge/transition planning. • Provide attention and consultation to the integration of physical and behavioral health for the IAFT® child/youth. Consultation and recommendations on Best Practices for medication regimen; sleep hygiene; immunizations and well-child visits; co-occurring health issues (i.e., asthma, diabetes, epilepsy); diagnosis clarification; developmental needs for the age & stage of IAFT® child/youth. • Oversight is informed by Psychiatric Consultation, Weekly IAFT® Team Supervision, Input from IAFT® Therapist, and clinical supervision and adheres to established standards for holistic care planning, behavioral health integration, and fidelity to the IAFT® model.
Procedure	• The Provider Agency has internal or contracted Psychiatric Staff to conduct Oversight at least once every 30 days to discuss IAFT® consumers on caseload. • Preference is to have consultation provided by a Child and Adolescent Psychiatrist. Psychiatric Staff with the following classifications must be licensed or certified, as appropriate, according to North Carolina General Statues and shall practice within the scope of practice defined by the applicable practice board: *Child and Adolescent Psychiatrist, Psychiatric Mental Health Nurse Practitioner, Physician Assistant*.
Fidelity Marker	• Documentation of Oversight every 30 days within the CCW database, concise content of the discussion. • Recommendations provided by the attending psychiatrist/appropriate provider, and follow-up continuously. Name and credentials of the Provider listed within the CCW Psychiatric Oversight form.

	• Documentation of overall progress, behavioral concerns/focus of treatment during therapy this month: presenting problem(s), including symptoms, behaviors, duration, severity, history, and any complicating factors. DESCRIBE ANY CURRENT SAFETY ISSUES such as danger to self or others, psychotic symptoms, violent behaviors, or ***any progress*** in the ***last 30 days***. Include summary of recent any recent crisis incident and follow-up needed. • If there are any indicators of placement disruption, document any guidance or consultation provided during monthly oversight to stabilize placement. Provide any follow-up from the last review. • Review and document any approved IAFT® Element Waivers to confirm continued clinical/administrative justification.
Best Practices	1. The IAFT® team is encouraged to share observations on diet, sleep patterns, and general health. Even small things like noticing that the youth is tired every afternoon might make a difference. 2. Monthly Psychiatric Consultation should reflect a holistic conversation per IAFT® youth assigned to the agency. Current research and best practices point to a holistic approach to health and wellness combining physical and behavioral health interventions as well as building resilience factors.

9. Proactive, Consistent, Teaching-Oriented Behavioral Intervention System

Purpose	• IAFT® is an EPSDT-covered service; therefore, behavioral interventions must be in place and utilized by IAFT® staff consistently and proactively that work to improve or maintain the consumer's behavioral health and prevent the development of addition behavioral health problems.
Procedure	• Documentation demonstrates IAFT® Treatment Parent(s) and staff's understanding of the model, proactive application of agency training/treatment model interventions aimed at improving consumer's functioning and daily interactions with others. Treatment Parent Service/Grid notes reflect use of interventions and consumer response. • Weekly IAFT® Team Supervision/and Monthly Psychiatric Oversight/Consultation notes show ongoing administration and clinical supervision for staff. • Weekly Individual/Family therapy notes, PCP interventions, Service/Grid note interventions/key address skill acquisition, symptom reduction, and changes in functioning and improvement in presenting behaviors.
Fidelity Marker	• Various documents, adherence tasks, and treatment interventions aimed at improving or maintaining consumer behaviors and functioning levels. *(Examples could include but are not limited to behavior/reward charts, clear & state expectations regarding rules, consequences, and behaviors in all settings)*.
Best Practices	1. Involving the youth in their treatment is key to making progress. If consequences must be issued, ask what they think is reasonable. Logical and natural consequences tend to be more effective than a solely punitive-based system. 2. Treatment Parent(s) in IAFT® should be able to reflect their knowledge of positive behavioral interventions in grid note documentation of interventions using the three-sentence structure that aligns with weekly behavior monitoring. 3. Daily Check-Ins with Treatment Parent(s), grid notes, and weekly supervision should all reflect a focus on positive replacement behaviors for the youth as the team works toward skill acquisition to mitigate prior maladaptive or unhealthy coping strategies to get needs met. 4. Weekly Behavior Tracking, Primary Treatment Parent Supervision interventions, and Positive Behavior support are documented on the Weekly Fidelity page in CCW.

10. Respite is Available 2 days a month for the IAFT® Parent(s) and Consumer

Purpose	• Planned Respite for the IAFT® parent provides a break from day-to-day caregiving; it is not meant solely for the crisis management of the consumer. • Use of Respite helps support relationships and prevent burnout and potential placement disruption. • Respite as a built-in program incentive helps the Treatment Parent(s) maintain a commitment to the service while attending to their emotional health and leisure needs.

Procedure	• The Provider Agency shall identify and document potential IAFT® trained and licensed Respite Parents for the youth. IAFT® Respite shall be identified as an intervention on the PCP. The identified IAFT® Respite Parent will be identified in CCW. • IAFT® Treatment Parent(s) should be encouraged to access and use Respite to maintain their functioning and stabilization of the placement as needed or identified during Weekly Treatment Parent Supervision. • IAFT® Staff should allow the consumer to meet prospective Respite Parent(s) to ensure a smooth transition. • IAFT® Respite Parent(s) should be provided with all current and relevant information on the consumer's daily routine, crisis plan, trauma triggers, and potential medical issues.
Fidelity Marker	• Respite is listed as a service on the Person-Centered Plan. The planned Respite Treatment Parent(s) will be identified in CCW on the Referral Intake. Although respite is highly recommended, it is not required to be used. Approved Waiver on file in CCW for exemption of Element for clearly stated clinical reasons for Respite over five (5) consecutive days.
Best Practices	1. Keeping the use of Respite woven into conversations with Treatment Parent(s), is an opportunity for the youth to practice the skills learned in another home environment, and a chance to build additional support helping to support the many benefits of Respite. 2. As the IAFT® Team notices the stress level of the Treatment Parent(s) increasing, Respite should be discussed in Weekly Supervision and/or daily check-ins to address placement stability, burnout prevention, and good use of model fidelity.

11. **Access to Specialized Therapeutic Services,** as indicated, and designed for the consumer and their support system via weekly therapy (individual and/or family)

Purpose	• Weekly in person* therapy is provided to the individual and/or family members to ensure treatment progress, reduction in presenting needs, and support of transition/discharge plans. • IAFT® is an integrated treatment service designed to improve the overall emotional health and functioning of the consumer and their family/support system; therefore, it is expected that the IAFT® therapist is internal to the agency and a fully integrated member of the IAFT® team. • Individualized weekly therapy is provided to or accessed by the consumer and their family or permanence. Clinical case formulation is well thought out by the treatment Clinician and is trauma-informed respective of the lived experience of the youth and family. • If additional specialized therapeutic services (i.e. TF-CBT, EMDR, substance use disorder, sexual offending, etc.) are recommended or needed and cannot be provided in-house by the Provider Agency then coordination and ongoing weekly treatment collaboration with an external therapist is documented and contractually agreed upon by the IAFT® agency, MCO, and treating Clinician. It is expected when an external Clinician is used that the Provider Agency IAFT® Therapist still stays involved via additional therapy modality (family or conjoint with IAFT® Treatment Parent(s)), weekly staffing, and consistent documentation of collaboration.
Procedure	• Identified Clinician (expected to be in-house) who provided child-centered, trauma-informed family-focused individual/family therapy as clinically appropriate every week (more if needed). • Therapy should address the defined focus of treatment as documented in the most recent CCA and PCP. • Therapy should remain strength-based and work towards the transition to a lower level of care or family reunification by skill acquisition and functioning, as guided by the clinician treatment model or theory utilized.
Fidelity Marker	• Documentation of weekly therapy for the individual and/or family supported by clinical documentation. • If the IAFT® youth has a family of permanence in place it is expected that routine Family Therapy is provided to assist in addressing Family system concerns which will ensure a successful transition back home (kinship placement) or to a lower level of care. • At minimum, one conjoint session a month that is held with the IAFT® Treatment Parent(s) and the IAFT® youth (other support if needed). • Documentation of weekly communication and collaboration with any external therapist approved by the MCO to provide the service.

Best Practices	1. IAFT® Therapist ideally should carry a caseload of 10-14 youth/families. Schedule therapy at the beginning of the week in case a make-up session is needed due to cancellation as therapy is required once a week. 2. For youth with a permanence plan which involves returning to family, kinship, or fictive kin placement, family therapy is planned and an integral part of treatment from the beginning of treatment. 3. Therapists should openly share skills, tips, and coping techniques with all members of the IAFT® team to support behavior change and healing for youth/family. Ideally, the IAFT® therapist should be able to educate CFT members on trauma-informed interventions and responses for the youth throughout the course of treatment. *Hybrid Model Requirements: 1) IAFT® weekly therapy: Clinicians may alternate weekly sessions between in-person (in the home, community, school or office) and virtual if clinically appropriate to meet the youth's and/or family's needs (no more than 50% virtual each month). 2) IAFT® Provider Agency will have internal procedures regarding Telehealth and virtual service provision. IAFT® Therapist and Provider Agency will be able to discuss these procedures and best practices with RRFF prior to implementation of Hybrid Model. 3) Agency will be prepared to return to in-person sessions for youth identified as unresponsive or not profiting from virtual based sessions.

12. Implementation of one of the Approved Training Models for Treatment Parent(s)

Purpose	• Agency will adopt and use a Treatment Parent training model showing some evidence of effectiveness as a training tool or Evidence-Based Practice model for the population served.
Procedure	• Agency has approved trainers and training curriculum for one of the following Training Models/Evidence-Based Practice Models verified by certification/accreditation documents provided to RRFF along with the approval letter from NCDSS (if needed) and demonstration of training for all IAFT® families/staff supported by treatment and integration of model fidelity: ○ Treatment Foster Care Oregon (formerly Multidimensional Treatment Foster Care) ○ Pressley Ridge ○ Collaborative Problem Solving ○ Teaching Family Model ○ Together Facing the Challenge ○ Resource Parenting Curriculum ○ CARE (Child and Residential Experiences: Creating Conditions for Change) for Foster Care ○ PRIDE (Parent Resources for Information, Development, and Education) ○ The Sanctuary Model
Fidelity Marker	• Training certificates in the model with contact hours in personnel files, and available to RRFF as needed. • IAFT® Training certificate for the Treatment Parent(s) should be in the file and uploaded to the parent facility in CCW. Certificate should reflect a minimum of (4) hours specific to the IAFT® Model. • Tenets of the chosen model are demonstrated in a variety of documentation, treatment interventions, and treatment philosophy utilized within the IAFT® service. • The Provider Agency will provide documentation of ongoing certificate or license if applicable for the chosen model upon recertification for the IAFT® Network.
Best Practice	1. Training Model interventions, best practices, and supervision structure of the chosen model should be evidence in agency documentation during treatment for the youth.

13. Weekly Documentation Inclusive of Efforts for Parental or Family of Permanence Engagement in IAFT® Treatment and/or Development of Natural Supports

Purpose	• IAFT® is designed to engage, empower, motivate, and strengthen family functioning and reintegration of the consumer into the family system upon treatment completion. • All members of the IAFT® team embrace a Systems of Care approach that is collaborative, strength-based, and solution-focused. All efforts should empower and motivate families to identify solutions that will remove barriers, increase healthy functioning, and build protective capacity for the consumer.

	• For those consumers without an identified involved family, IAFT® is designed to develop and strengthen community connections based on natural support for the consumer. o *If the consumer is in the custody of the local Department of Social Services or lacks natural support, the IAFT® Provider Agency and the Child & Family Team will work diligently to locate, build, and sustain in creative means potential forms of community mentors or natural support that could participate in consumer's plan of treatment, recovery, and transition to next level of care.* o *These efforts and results are to be documented every week under this Element*.
Procedure	• Every week, IAFT® staff documents and addresses family/parent and natural support engagement, shared parenting, and decision making, as well as ongoing solutions to improve system functioning. • IAFT® staff documents any barriers to meeting this element as well as ongoing efforts to reduce barriers. • Weekly documentation should reflect what occurred "that week" to support moving the youth forward in treatment, skill building, and positive relationships aimed at successful behavioral outcomes. • Documentation of Element is included in Weekly Team Supervision and Psychiatric Oversight documenting in CCW database.
Fidelity Marker	• Clear, concise documentation of weekly efforts and results of engagement of family and/or natural supports for the consumer. • Documented follow-up on recommendations to identify, remove or reduce barriers to element or permanency planning for the youth.
Best Practice	1. For youth in the foster care environment, achieving permanency with a family or through strong connections to natural supports is vital to long-term success and improved quality of life. The IAFT® team is charged with the task of ensuring every week efforts are made, barriers are identified and removed to enable the permanency plan to progress and be achieved. 2. For older youth who do not have an identified permanency plan with a family system, then efforts are to be documented and made to achieve independent living skills, employment, or academic skills which will enable the youth to "age successfully" of out treatment care.

14. Integration of Model Fidelity

Purpose	• All activities converge to support compliance with IAFT® Elements throughout treatment interactions, documentation, and consumer outcomes.
Procedure	• Agency's adherence to all practice Elements and general Best Practice standards are evidence in the totality of service provision and documentation.
Fidelity Marker	• Agency compliance will be assessed during scheduled Compliance Reviews and Continuous Quality Improvement activities by RRFF.
Best Practice	• All IAFT® staff will attend "Implementing IAFT® with Fidelity" training six (6) months after their initial New IAFT® Staff training to support understanding of model fidelity. • All IAFT® Treatment Parent(s) will attend Implementing IAFT® with Fidelity training annually to ensure continued model fidelity. • Any major deviation from the model will be reflected in ongoing compliance and fidelity monitoring with sufficient time allowed for improvement.

1. Sarah Horwitz, Patricia Chamberlain, John Landsverk, Charlotte Mullican (2010), Improving the Mental Health of Children in Child Welfare Through the Implementation of Evidence-Based Parenting Interventions
Sharon Riley, PH.D., Arnold Stromber, PH.D., James Clark, PH.D. (2005), Assessing Parental Satisfaction with Children's Mental Health Services with the Youth Services Survey for Families
Ramona Denby, Nolan Rindfleisch, Gerald Bean (1999), Predictors of Foster Parent's Satisfaction and Intent to Continue to Foster
Elizabeth Farmer, Barbara Burns, Melanie Dubs, Shealy Thompson (2002), Assessing Conformity to Standards for Treatment Foster Care
Cheryl Buehler, Kathryn Rhodes, John Orme, Gary Cuddeback (2006), the Potential for Successful Family Foster Care: Conceptualizing Competency Domains for Foster Parents
Family Foster Treatment Association (1998-2013), Program Standards for Treatment Foster Care

2. US Department of Health and Human Services. (2012). *Substance Abuse and Mental Health Services Administration*. Retrieved from Resources for Child Trauma-*Informed Care: https://www.samsha.gov/*
3. Department of Health and Human Services. *(2014). Retrieved from Substance Abuse and Mental Health Services Administration: https://store.samsha.gov/system/files/sma14-4884.pd*

Data Collection Protocol and Outcomes Measures

The following timelines for IAFT® consumer data collection Elements are to be completed and entered in the CCW Database before admission, at intake, during treatment (i.e. daily, weekly, and 3-month intervals), at discharge, and at 3- and 12-month follow-up after the discharge date. In addition are the selected outcome assessment measurements for the IAFT® program.

Element/Measure	Purpose	Responsible Party	Timeline	Location in CCW
Referral/Intake Screen/Form	Capture and report consumer's intake and referral information, including demographic and background clinical information supporting IAFT® admission criteria.	• Referral Source • IAFT® Agency	• Before admission • Updated for accuracy upon admission. • Medication and Diagnoses updated throughout treatment as changes occur	**Manager Tools** ➢ Prior to-Admission ➢ Referral Intake
Adverse Childhood Experience (ACE) Questionnaire	Capture and report consumer's prior trauma experiences to help guide trauma-informed care and treatment interventions.	• IAFT® Agency Clinician: gather data following rapport building. • IAFT® Team Member: enter data	• Within the first 45 days of placement. • At the Clinician's discretion after trust and rapport building.	**Manager Tools** ➢ Admission ➢ Whole Health ➢ Ace Questionnaire
Social Determinants of Health – Unmet Needs	To identify unmet needs experienced by the youth/family of permanence prior to treatment to develop interventions and support for youth/family of permanence during treatment to support discharge and permanency planning.	• IAFT® Agency Team Members	• Gather information via self-review, review of clinical records, or existing knowledge of youth's history. • Complete Questionnaire in CCW within 5 business days from admission date	**Manager Tools** ➢ Admission ➢ Whole Health ➢ Social Determinants of Health
Documents	Uploaded copies of current documents to support IAFT® Treatment: • **PCP**: reflecting IAFT®, planned respite/provider, individualized goals and interventions, *updated at least annually.* • **CCA:** reflecting diagnoses & treatment/service	• IAFT® Agency Team Members	• Uploaded within 5 days of business from admission date. • Updated/Uploaded annually or as needed if major changes or revisions are made. • Indicate document date when uploaded	**Manager Tools** ➢ Upload Forms

	recommendations, *updated annually.* • Initial Authorization from MCO • **Crisis Plan:** reflecting contact information for IAFT® Team during crisis incidents and plan to support youth during incidents of crisis/escalated behavior, *updated annually or after event.* • Current **Consent Form** for RRFF follow-up			
Children's Global Assessment Scale *(CGAS)*	Measures the most impaired level of general functioning for a specified time period.	• IAFT® Agency Team Members	• Within 5 business days of admission • Every 3 months during treatment (from date of admission) • Within 5 days of discharge	**Manager Tools** ➢ Admission--CGAS ➢ Intervals -- CGAS ➢ Discharge--CGAS
EPSDT Request (*Early Periodic Screening & Diagnostic Treatment)*	Prior Approval is needed to cover the funding for IAFT® services.	• IAFT® Agency Team Members	• Before Admission: signed & dated. • Signed Annually (valid for 12 months)	**Manager Tools** ➢ Upload Forms
Weekly Fidelity • Daily Contact • Behavior Tracking • Treatment Parent & IAFT® Team Supervision • Weekly Engagement of Family of Permanence or Natural Supports • Weekly Therapy	To gather and monitor data regarding: a) type of daily contact 5 days per week b) measure Treatment Parents perceived effectiveness of supervision and stress level. c) Documentation of primary IAFT® Parent Supervision Intervention d) Efforts and incidents of shared parenting and engagement with natural support e) Date and type of weekly IAFT® therapy. f) Frequency of targeted/problem	• IAFT® Agency Team Members	• Completed during daily phone call/personal contact with IAFT® Treatment Parent(s) and Weekly IAFT® Team Supervision meeting. • Submitted in CCW daily or within 5 business days of occurrence.	**Manager Tools** ➢ Intervals ➢ Weekly Fidelity

	behavior, replacement behavior and measurement of consumer's motivation and engagement to effect behavioral change. g) Summary of Weekly Team Supervision and documentation of positive behaviors identified.			
Psychiatric Oversight	A summary of the Monthly Psychiatric Oversight & Consultation meeting with psychiatric provider recommendations for IAFT® treatment and overall youth health/wellness. Below items shall be address as well: • Monitor and respond to disruption potential. • Assess ongoing need for approved IAFT® Element waivers. • Identify current focus of treatment/therapy and therapy modality. • Identify resilience/protective factors. • Document crisis incidents within the month. • Monitor respite utilization. • Assess and monitor whole-child treatment, including progress/regression toward goals, permanency and discharge planning, HEDIS measures, and interventions to	• IAFT® Agency Team Members	• Every month for youth while in treatment. • Submitted in CCW within 5 business days of occurrence	**Manager Tools** ➢ Psychiatric Oversight

	address unmet needs.			
Attendance Calendar	Record the location of treatment for that day: • IAFT® Home • Respite (with respite home indicated) • Psychiatric or Medical Hospitalization • Therapeutic Leave • AWOL • Detention • Non-Billable location/event	• IAFT® Agency Team Members	The attendance calendar auto-populates each day based on the most recent verified entry. IAFT® Agency Team members shall: • Verify entries weekly, updating the location of youth as needed. • entire month to be verified by 3rd business day of the following month.	**Manager Tools** ➢ Intervals ➢ Attendance Calendar
Discharge Summary	To document a summary of treatment and placement outcomes. • The final CGAS and ROLES scores are provided. • Brief Narrative regarding the nature of discharge and treatment outcome.	• IAFT® Agency Team Members	Within 5 business days of discharge	**Manager Tools** ➢ Discharge ➢ Discharge Summary
Consent to Release Contact Information	Developed to obtain parent/legal guardian's consent to release information post-discharge.	• IAFT® Agency Team Members	• Uploaded upon admission, effective for 2 years. • At discharge, confirm validity for at least 1 year past discharge date, obtain & upload updated consent if needed within 5 days of discharge.	**Manager Tools** ➢ Upload Forms
Legal Guardian Satisfaction/Discharge Survey	Measures level of satisfaction of Parent/Guardian	• RRFF Employee	• During discharge compliance review • If feasible can be completed within the last month of planned discharge to ensure data collection	**Collected Outside of CCW**

Treatment Parent Satisfaction Survey	Designed to assess the opinions about IAFT® Treatment delivery by the Network Provider	• RRFF Employee	• At scheduled intervals as determined by RRFF	**Collected Outside of CCW**

General guidelines for data collection, entry, and administration of outcomes assessments/instruments are as follows:

1. Information entered in the CCW Database should be reviewed for accuracy before "submission" and then routinely upon entry to ensure clean data.
2. Enter all paperwork and assessment scores/results into the database of CCW within 5 business days of each data collection interval.
3. Update diagnoses, medications, and contact information as changes are made during treatment, or upon clarification upon admission. Updated PCPs and new CCAs uploaded as changes are made (at least annually).
4. Due to changes to the Comprehensive Crisis Plan being separated from the PCP document, please ensure the CCP is uploaded at admission and as updated/revised.