

**Implementing Knowledge Translation in Care Coordination to Address Complex
Behaviors in Foster Youth**

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NURS 703B: DNP Project

Spring Term, 2022

Submitted to Patricia Barfield, PhD, RN, PMHNP-BC - Chair

This paper is submitted in partial fulfillment of the requirements for
the Doctor of Nursing Practice degree.

Abstract

Purpose: To support the health and wellness of children and families in the foster system through knowledge translation and quality improvement.

Background: Youth in foster care experience traumatic stress and complex behavioral problems that can manifest as difficulty sleeping, poor appetite, and regressive behaviors. Resource parents are often unaware, unprepared, and/or feel unsupported in managing complex behaviors. There is a gap in the provision of evidence-based, easily accessible, and actionable guidance to help manage complex behaviors.

Methods and Intervention: The Knowledge to Action (KTA) framework guided the process of knowledge creation, adaptation, and implementation. Three evidence-based/trauma-informed brief information tip sheets (BITS) targeting trauma-sensitive behaviors (sleeping, eating, and toileting) were created. The BITS were implemented in a care coordination toolkit for youth in foster care. Implementation was evaluated via retrospective chart audits.

Results: The primary outcome was a transfer of evidence-based, trauma-informed knowledge (i.e., BITS) to care coordinators and resource parents. Sixty-two percent of youth that entered custody during the survey period had resource parents who were given toolkits containing the BITS. One-hundred percent of toolkits distributed following implementation contained two or more BITS.

Conclusion: KTA was an effective model to develop and test the BITS. The final product was a compilation of trauma-informed, solution-oriented methods based on best practice in a simple format for quick dissemination and implementation. The BITS were designed to promote attachment security, child emotional regulation, and provide parent management training with a highlight on felt safety. Continued study of the actionability/utilization of the BITS is recommended.

Keywords: Foster youth, resource parent, evidence-based intervention, trauma-informed care, complex behavior, knowledge translation, quality improvement

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Problem Description

Youth placed in foster care experience traumatic stress that can lead to complex behavioral and developmental problems. These complex behaviors often manifest as emotional upset, behavioral changes, difficulty sleeping, poor appetite, and regressive behaviors requiring higher levels of care and threatening placement stability (Solomon et al., 2016; The National Child Traumatic Stress Network [NCTSN], 2008). The repeated exposure to traumatic events experienced by youth in foster care can lead to toxic stress, poor physical health and developmental delays, highlighting the importance of early intervention and trauma-informed care (TIC) (Hornor et al., 2019; Shonkoff et al., 2021). Compared to youth not placed foster care, foster youth are six times more likely to exhibit behavioral problems (Turney & Wildeman, 2016). Resource parents, formally known as foster parents, often feel unprepared to manage the challenging and complex behaviors exhibited by youth in their care and are in need of more resources and support (Barnett et al., 2018; Hebert & Kulkin, 2018; Murray et al., 2011). Difficulties dealing with complex behaviors can disrupt placements and compound the trauma (Hebert & Kulkin, 2018).

In 2019, nearly 11,000 Oregon youth were placed in foster care with over 60% experiencing two or more placement disruptions (Office of Reporting, Research, Analytics and Implementation [ORRAI], 2020). A 2018 audit of the Oregon Department of Human Services (ODHS) identified a lack of training and support for resource parents as negatively influencing the state's ability to retain resource family homes perpetuating placement instabilities for foster youth in Oregon (Secretary of State, 2018).

In rural Oregon, a care coordination team was developed to support the health and wellness of youth and families in the foster system. Care coordinators provide general information to resource families on complex trauma, adverse childhood experiences (ACEs), and building resilience. The care coordinators compile youth-specific health, legal and supportive information into a toolkit that stays with the youth during care transition, building a framework for continuity of care in a system challenged by constant changes. A missing component of the toolkits identified by the care coordination team is evidence-based, accessible, and actionable information that resource parents can use to manage complex behaviors.

Available Knowledge

A review of the literature demonstrates that most youth in foster care have faced some form of abuse or neglect and as a result they have developed altered coping skills and ways of reacting to challenges (American Academy of Pediatrics [AAP], 2015; NCTSN, 2008; Solomon et al., 2016; Strolin-Goltzman et al., 2017). Chronic child traumatic stress leads to constant activation of the body's stress response and alters the brain structure and function leading to higher incidences of externalizing behaviors and difficulties regulating behavior, common causes for foster placement disruption (Goemans et al., 2017; Strolin-Goltzman et al., 2017; Purvis et al., 2013). When provided proven strategies to manage the challenges resource parents can buffer the impact of traumatic stress and help youth build resilience (Strolin-Goltzman et al., 2017).

In Oregon, new resource parents are required to take 24 hours of training that briefly introduces the concept of complex trauma and behavior needs of youth in foster care but stops short on actions they can take to manage behaviors. Additional online training and support programs are available but often come with large time commitments and costs. For example, programs such as KEEP, a 90 min per session support group is formatted over 16 weeks, and

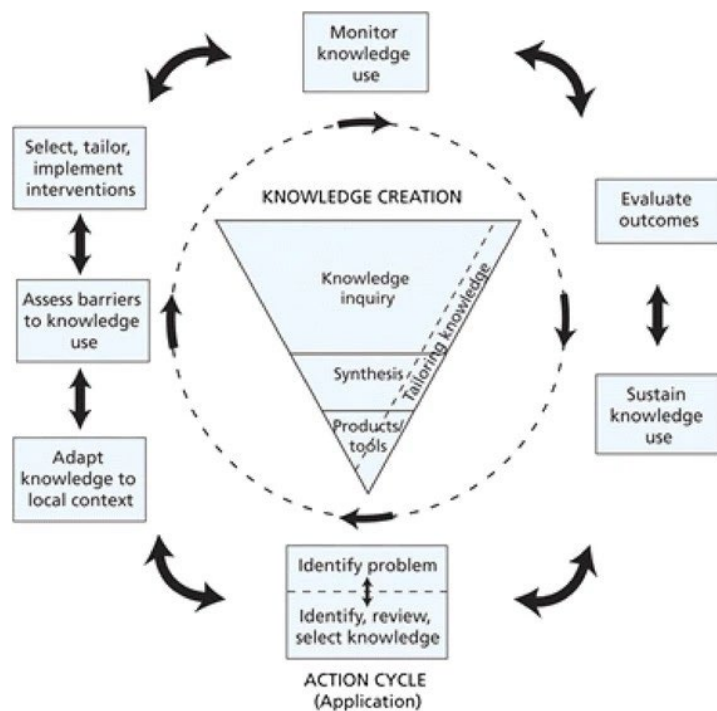
Foster Parent College (FPC), an online learning platform targeted to specific behaviors with 2-6 hours per class, are options resource parents can purchase (KEEP, n.d.; Northwest Media, Inc, 2021). The healthcare system is another avenue for resource parents to access support but primary care and mental health resources vary in different communities. In Oregon, a registered nurse completes an assessment and provides general information upon entrance to care but this visit occurs within the first few weeks of placement during a time that can precede challenges or concerns. In short, resource parents have access to a myriad of online and in-person information sources and supports. The gap exists, in the provision of evidence-based, easily accessible, and actionable guidance on how to manage complex behaviors.

Rationale

Knowledge Translation (KT) is a dynamic and iterative process that includes the synthesis, dissemination, and exchange of knowledge to improve health outcomes (Canadian Institutes of Health Research [CIHR], 2020). The Knowledge to Action (KTA) framework (Figure 1) was chosen for this project due to its integration of the local context and practice when adapting or developing evidence-based intervention (Rycroft-Malone & Bucknall, 2010, Chapter 10). A strength of the KTA framework is the participation of the end user in the selection and tailoring of the implemented intervention to their local context with an integration of contextual knowledge in developing the intervention (Rycroft-Malone & Bucknall, 2010).

Figure 1

Knowledge to Action Framework



Note. This figure depicts the knowledge translation process. From “Lost in Knowledge Translation: Time for a Map?” by I.D. Graham, J.L. Logan, M.B. Harrison, S. E. Straus, J. Tetroe, W. Caswell and N. Robinson, 2006, *The Journal of Continuing Education in the Health Professions*, 26(1), p.19 (DOI: 10.1002/chp.47).

The care coordination team identified resource parents are most challenged with complex behaviors exhibited by foster youth in the first 60 days of placement. The specific behavioral areas identified by the care coordination team included sleeping, eating, toileting, and behavioral outbursts (M. Kirkpatrick, personal communication, May 3, 2021). They requested the creation of evidence-based information and interventions that could integrate in their existing toolkits.

Effective resource parent training and support materials are child centered and focused on providing trauma informed, solution-oriented methods based on best practice (Children need amazing parents [CHAMPS], 2019). Interventions should promote attachment security, child emotional regulation, and provide parent management training models (American Academy of

Pediatrics [AAP], 2016). Trauma informed material focused on parent training implemented as part of a toolkit can be an effective means to disseminate interventions and best practices to improve the quality of care (Hempel et al., 2019). Multiple evidence-based programs and guidelines grounded in trauma informed methods have shown promise in behavioral improvement but lack a simple format for quick dissemination and implementation (Becker Razuri et al., 2016; de Graaf et al., 2008; Purvis et al., 2013).

Specific Aims

The overarching aim of this process improvement project was to utilize knowledge translation to provide a practice improvement for a care coordination team in rural Oregon to better support resource parents in managing complex behaviors in foster youth. The project had three specific aims, to:

- 1) Synthesize and adapt evidence-based knowledge into brief information tip sheets (BITS) targeting complex behaviors by December 1, 2021.
- 2) Facilitate the implementation of the BITS into 90% of foster youth toolkits by January 30, 2022.
- 3) Assess and monitor knowledge use of BITS by resource parents through a record audit from January-April 2022 with a goal of 75% of the resource parents reporting that they accessed and used the BITS to manage complex behaviors.

Methods

Context

The context for this practice improvement project is a foster youth care coordination team in rural Oregon. The team includes a physician, a registered nurse and a human development and

family services specialist. Each month, the team adds approximately 10 new foster youth to their case load. The care team meets with the resource families over multiple appointments in the first 30-days of youth's placement, provides continued support throughout the time in care, and follows the youth to new resource homes if there is a change in placement.

Interventions

The knowledge translation intervention applied the KTA framework (Figure 1), which is comprised of two parts, knowledge creation and the action cycle (Graham et al., 2006). The knowledge creation process directed the gathering and tailoring of evidence-based information and interventions into the BITS to address knowledge gaps. The knowledge creation process consisted of three phases: knowledge inquiry, knowledge synthesis, and creation of knowledge tools and/or products. Information from studies, knowledge tools/products (i.e., Trauma Based Relational Intervention (TBRI) program), and evidence-based practice guidelines from the American Academy of Pediatrics and the National Child Traumatic Stress Network (NCTSN) resources were synthesized for the BITS. As evidence-based interventions were gathered, synthesized, and filtered they were condensed and focused towards the end user, the resource parent, to create the final BITS (Graham et al., 2006; Rycroft-Malone & Bucknall, 2010).

The KTA action cycle guided implementation. Problem identification took place through the review of literature, identification of resource parent trainings in Oregon, and meetings/interviews with the care coordination team. Determination of the knowledge gap was identified through assessment of care coordination current toolkit materials. Identifying and selecting knowledge was completed through appraisal of available evidence-based interventions for the targeted complex behaviors.

The next steps of the action cycle took place dynamically as individual BITS were created, reviewed, and refined. Adapting the knowledge to local context was completed through consultation of subject matter experts and materials as well as ensuring a trauma informed focus of all the information and interventions on the BITS. A total of four BITS sheets (e.g., sleeping, eating, toileting, and behavior outbursts) were planned for creation, use, and study. However, due to project time constraints and the cross-cutting nature of behavior outbursts, the care team and literature supported targeting three core complex behaviors—sleeping, eating, and toileting (see Appendix A for final BITS).

Barriers to knowledge use were assessed through multiple team reviews of the initial BITS leading to a simplified template. The template took into consideration the requests of the care team to create easily accessible, and actionable guidance on how to manage complex behaviors when they are happening. Sections covered in each BITS include; a brief description of the behavior and presentation of it, what is known about the behavior specific to trauma and foster youth, and a table of interventions with a blank column for resource parents to note what worked or didn't work with the interventions tried.

Tailoring the intervention occurred during the formation of the templates and with the addition of educating resource parents about the BITS. The care team provided education on how to access and utilize the BITS during delivery of the toolkits. Implementation began with placing the initial BITS into the existing toolkits on 1/28/2022.

Study of the intervention

The KTA action cycle continued to guide the study of the intervention as knowledge use was monitored. To monitor knowledge use *smart phrases* were created for use in the electronic

medical record to quickly import established survey questions (Appendix B). The survey questions were designed to collect quantitative and qualitative data at 30 and 60-days from placement of youth into the home. Questions explored resource parents experience with access and utilization of the BITS. Survey items asked if resource parents used the BITS, which ones they used, and if they found them easy to access. Response options were dichotomous (yes/no), a 5-point Likert scale (low to high), and space for open-ended feedback. A second set of survey items targeted the care team to evaluate implementation and the provision of resource parent education. A retrospective electronic medical record audit was completed at 30, 60, and 90 days following the implementation of the BITS into the toolkits.

Measures

Knowledge synthesis (Specific aim 1) was evaluated through the iterative process of the BITS creation with success measured by approval from all care team members and finalization of each BITS resource. Implementation (Specific aim 2) was measured through chart audits assessing how many of the toolkits given contained the BITS with the goal of 90%. The number of youth added to the care team's case load was tracked and compared to how many received a toolkit. Chart audits occurred monthly for 3 months following implementation of the BITS into the toolkits. An additional process measure was the number of resource parents given direct education on the location and use of the BITS to assess if further tailoring of the intervention was needed. The number of BITS placed in each toolkit was also tracked. Assessment of knowledge use (Specific aim 3) measures included the number of resource parents reporting using the BITS for a behavior. Survey data on the ease of access was used to support the extent of accessibility. Two process measures used to assess additional education needs from the care team included if the resource parent was informed of the BITS in the toolkit and if they were the foster youth's

first placement home. A single-item Likert scale question was used to survey how helpful the information or intervention was for the specific behavior and to quantify actionability.

Analysis

Descriptive statistics (i.e., counts, percent) were used for analysis. The number of youth coming into foster care, the number of resource parents receiving toolkits, and the percentage of toolkits containing the BITS were tracked to evaluate implementation. Knowledge use (i.e., how many resources parents reported utilizing a BITS) was compared to the process measure of how many BITS were given out over the time of the project. Ease of use and reported helpfulness of the intervention data were compared to the number of BITS sheets utilized to determine if the BITS were actionable.

Ethical Considerations

This knowledge translation project was submitted to the Oregon Health and Science Investigational Review Board (IRB) and the IRB for the care coordination teams' organization and was determined to not be research with no further review needed. Foster youth electronic medical records were accessed to imbed/obtain survey data. No collection of personal health information took place for the purpose of this project.

Results

Initial steps and evolution of knowledge transfer

Aim 1: Synthesize and adapt evidence-based knowledge into brief information tip sheets (BITS) targeting complex behaviors, completed March, 2022. The knowledge creation phase of the KTA model took place over 5-months through a literature review process. Some steps of the KTA action cycle occurred simultaneously during the knowledge creation phase (Appendix C). *Identify, review and select knowledge and adapt knowledge to local context* steps

were completed through an iterative review process. *Barriers to knowledge use* were addressed during care team meetings and the development of a common template. Each BITS underwent extensive review by care team members and content experts for the final revision. The *select, tailor, implement interventions* began following the final iteration of each BITS as they were placed into the toolkit. Care team members educated resource parents on the BITS location and use. Following, the care team member implemented new smart phrases in their charting for tracking the use of BITS. During the implementation phase an additional care team site was added to increase the possible number of outcome measures and dissemination. The first BITS was approved and placed in the toolkits starting in January, 2022 which allowed for survey data collection to begin.

Process measures and outcomes

Aim 2: Facilitate the implementation of the BITS into 90% of foster youth toolkits, completed April, 2022. *Monitoring knowledge use (process) and evaluating outcomes (placement)* began with survey chart audits 30-days after the first two BITS were placed in the toolkits. The first 30-day audit revealed no surveys were completed. Thirteen children had come into state care during this time. Two children left state custody before the toolkits were provided. Of the remaining 11, there was no documentation the toolkits with BITS were provided to resource parents.

The second chart audit took place 60-days from the start of BITS placement in the toolkit. During this period, 19 additional youth were placed into state care for a total of 30 foster youth. Subsequently, 5 of the 19 youth were re-located to counties outside the project/care team purview and one from the prior month returned to home, leaving a total of 24 youth under the care coordination teams metrics. Of the 24, only 7 (29%) had documentation that the toolkit with

the BITS was given to the resource parent and education on the BITS was provided. No survey data was completed utilizing the smart phrase.

The third chart audit took place 90-days post start of the intervention. During this time 13 new youth entered care. One additional youth from the month prior had returned home but the biological parent requested the toolkit so that youth was not removed from the final count which was 37. During this 30-day time period 16 more youth's records documented that the toolkit with BITS was implemented and education was provided. No survey data was completed utilizing the smart phrase.

In summary, of the 37 total youth placed into state care over the 3-month time frame, 23 youth records (62%) had documentation that the toolkits were given to the resource parent. Of the 23 toolkits implemented 100% contained the BITS. The third BITS was finalized just before the last chart audit took place. Only one toolkit had all three BITS implemented, the remainder had two BITS. No completed smart phrase survey data was found in chart audits over the 3-month period.

Contextual elements, observed associations and unintended consequences

Timeliness and placement movement were contextual factors that effected the results of this project. The time of youth entry into custody and the initial care team communication with resource parents varied in part due to a delay in the ability to contact resource parents or social workers. The average time from state custody placement to toolkit distribution was 30-days with a few being over 60 days. Many of the youth who entered custody during the survey period had not undergone the care teams' full intake process including the delivery and education of the toolkits. The movement of youth across the system also influenced the care team's ability to distribute the BITS/toolkits. During the 90-day survey period, multiple youth transferred to

counties outside of the care team metrics or returned to a biological home placement. This constant placement movement is unfortunately a common variable with foster youth as many are transitioning home multiple times throughout foster care (ORRAI, 2020).

Missing data

Aim 3: To assess and monitor knowledge use of BITS by resource parents through a record audit with a goal of 75% of the resource parents reporting that they accessed and used the BITS to manage complex behaviors, unmet. No survey response data was available during the 90-day audit period to determine if resource parents accessed and used the BITS to manage complex behaviors. This finding while disappointing can be understood in the context of time delays and demands.

Discussion

Summary

The KTA model proved to be a well-suited model for synthesizing evidence-based material specific to the local context of a foster care coordination team to create a resource for addressing complex behaviors experienced by foster youth. The first and second aims of the project were met through the creation and implementation of the BITS into the care teams toolkits. Data collection through medical record audits proved to be more challenging than anticipated due to variable time frames for intake processing, challenges with inconsistent timing of delivery of toolkits and foster youth movement of placements. The average of 30 days from the time the youth enter custody until the toolkit was delivered to the resource parent was found, highlighting the need for a longer evaluation time of the outcomes. The third aim of the project to assess and monitor knowledge use, proved to be a lofty goal in the three-month timeframe. Contextual factors limited survey implementation in the medical records. During implementation

phase the care team had an influx in youth coming into state custody as well as other staff limitations causing delays in their normal workflow. They were unable to set planned reminders for surveys to launch, and thus no surveys were collected. The challenges in variable time frames and variable numbers of youth entering state custody exemplifies the fluctuating nature of the foster system and the continued need for dynamic solutions to create successful changes.

The project was successful in creating an evidence-based resource tailored to the needs of the care coordination team to aid resources parents in addressing complex behaviors. The care team expressed satisfaction with the product and were excited to pilot the BITS in the care toolkits. In particular, the trauma informed focus of the BITS was well-received and was a driver for expanding the use of them to a third county before completing a trial in the first two counties alone. The end result of BITS was a compilation of trauma informed, solution-oriented methods based on best practice in a simple format for quick dissemination and implementation. The BITS are designed to promote attachment security, child emotional regulation, and provide parent management training models with a highlight on felt safety. This was the overarching goal of the project at its conception.

Interpretation

The KTA framework is praised for its ability to be dynamic and build knowledge that is tailored to the user's needs (Rycroft-Malone & Bucknall, 2010, Chapter 10). The ability of the knowledge creation steps to occur simultaneously with the action cycle allowed the BITS to be created and adapted throughout the process of review with team members. This led to a successful outcome of the first aim of the project. In addition, the second outcome was successful as all toolkits that were given out during the time of the audit contained 2 or more of the BITS sheets. This again is a compliment to the dynamic process of KTA, as implementation

of individual BITS could begin as each was complete with the ability to go back and tailor if needed.

The challenge to KT in healthcare is ensuring that barriers are continuously addressed as knowledge is implemented into practice (Graham & Straus, 2013, Chapter 3). This challenge was reflected in the monitor knowledge use and evaluate outcome steps of this project as unidentified barriers to gathering data were found during audits of survey data. While data was collected on the successful implementation into the toolkits, the information also revealed the challenging time lines of foster care placements and constant changes. Because no survey data was collected on resource parent use of the BITS no evaluation of the actionability of the BITS could be completed at this point. As Rabinowicz & Ray discussed, KT is partially a social process of change that takes place over time and is impacted by the practice environment and the individual practitioner (2018). Graham & Straus, also define barriers to successful KT as ones of practice environment, including time and organizational constraints, as well as knowledge such as lack of familiarity and forgetting to implement (Graham & Straus, 2013, Chapter 3). This was observed through the challenges of implementing a new process in the established workflow of the care team leading to poor uptake by factors outside of this projects control. With KTA's flexibility to return to previous steps assessing barriers to facilitation can be repeated with a new focus on gathering and evaluating outcomes of actionability related to the BITS.

Limitation

Generalizability and utilization of the BITS may be limited due to the tailoring of the content and format to the needs of the care team. Specific subject matter literature was requested to be included in the BITS, which could be seen as a bias of the content selected for inclusion. In consideration of this, the majority of the evidence-based content included on each BITS was

from a variety of sources including but not limited to the AAP, the NCTSN, the Child Mind Institute, and the TBRI principles. An additional limitation of the BITS is the need for education on how to access them and the best way to utilize the information on them. To overcome this limitation and ensure ease of use the BITS were designed in a simple format with a trauma informed focus highlighting simple ways to help the child feel safe.

Conclusion

Addressing complex behaviors in youth in foster care is a multifaceted issue where no one approach fits all. Variable time frames for care coordination and movement of placements presents challenges in addressing timely delivery of resources. The KTA model proved to be a well-suited framework for developing and testing the BITS through its dynamic approach of integrating the users' needs as well as flexibility in the process. With more cycles of testing to determine if the BITS provide the intended assistance for resource parents the implications for their use could be expanded to other outlets such as primary care physicians' offices and state training workshops for resource parents. With their simple format and ability to individual information to the child the BITS could serve as model for the creation of additional information sheets addressing further behavior needs. The care team partnered with for this project will have the BITS template and intend to create more BITS for other common behaviors. The next step of the KTA model which was not able to be addressed is *sustain knowledge use*. Continued study of the accessibility and actionability of the BITS is recommended with adjustments as needed for successful use with resource parents. Through maintaining a trauma informed focus and felt safety the BITS have the potential to improve the lives of youth in foster care. The BITS can act to guide resource parents in understanding and addressing complex behaviors lessening the chance of placement disruption and improving the resiliency of the youth in their homes.

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Appendix A

BITS for Behaviors


Figure A1

BITS for Sleep Behaviors


BITS:

Behavioral Information Tip Sheets

Sleep behaviors for youth in foster care



Take a deep breath (Together if you can). Staying calm can help sooth fears and anxieties.

Trauma Lens: How is this harder for the child in my home? 


Your child is doing the **best** that they can right now... Its **our** job to **help** them.

- Ask yourself...What is behind the behavior? Is there an unmet need my child has?
- Stay calm. Calm voice, calm face, calm body can help them calm down too.
- Be consistent and be predictable.

Brain and body response to trauma:

- Do they **feel** safe? Ask them. Feeling safe is different than being safe.
 - How can you help them know they are safe?

✓ Fear increases emotions and the fight or flight response making it hard for your child to listen and respond. They may not be able to be calm or use the "thinking" part of their brain until they feel safe again.

What about sleep? 

Sleep is one key to how well a child can think, act, and learn.

Without enough sleep, bodies, behaviors, and emotions are harder to control. "Tired-and-wired," or acting hyper when they over-tired can happen but it is still important to get them to bed.

Use these tips to help everyone get a better night sleep. Keep track of what works best. Remember these things take time so be patient and consistent.

*Talk with your child's doctor before starting any medications, if they have loud snoring, pauses in their breathing or if you have other concerns.

| What you might see: | What you can do: | What we have tried: <small>How did it work?</small> |
|----------------------|---|--|
| Trouble going to bed | Have a regular bedtime every night | |
| | Create a soothing bedtime routine every night (bath, book/story time, tucking into bed) | |
| | Provide regular physical activity during the day (but not right before bed) | |
| | Start calming down 1 hour before bed | |
| | No electronics in the bedroom | |
| | Give a calm verbal reminder that bedtime is coming to help with transitions | |

Flip to the back for more tips

| What you might see: | What you can do: | What we have tried: <small>How did it work?</small> |
|------------------------|---|--|
| Trouble falling asleep | No screens 2 hours before bed | |
| | Warm bath to calm the body | |
| | Dim light and a comfortably cool room | |
| | Soothing sounds or music (This may be distracting for some children if not a constant "white noise") | |
| Trouble staying asleep | Take care of body needs before bed (water, potty time, healthy snack) | |
| | Comfort objects (blanket or stuffed animal) <small>*Only for 1-year-old and up per safe sleep recommendations*</small> | |
| | Help them stay in their own bed during the night (Calmly walk them back to bed and reassure as needed) | |
| Nightmares | Accept, respect, and try to understand their fears (Be present and reassuring) | |
| | Reassure them that dreams are not real | |
| | Encourage bravery (and reward it) | |
| | Use a night-light or ceiling star projector | |
| | Room checks together before bed | |

Find out more information at:

- Healthychildren.org
- childmind.org/resources
- Karyn Purvis Institute of child development: TBRI at child.tcu.edu/about-us/tbri

Figure A2

BITS for Eating Behaviors

BITS: Behavioral Information Tip Sheets

Eating behaviors for youth in foster care

Take a deep breath (Together if you can). Staying calm can help sooth fears and anxieties.

Trauma Lens: How is this harder for the child in my home?

Your child is doing the **best** that they can right now... **Its our job to help them.**

- Ask yourself...What is behind the behavior? Is there an unmet need my child has?
- Stay calm. Calm voice, calm face, calm body can help them calm down too.
- Be consistent and be predictable.

Brain and body response to trauma:

- Do they feel safe? Ask them. Feeling safe is different than being safe.
- How can you help them know they are safe? (Reassure them you will feed them)

- ✓ Fear increases emotions and the fight or flight response making it hard for your child to listen and respond. They may not be able to be calm or use the "thinking" part of their brain until they feel safe again.
- ✓ Play removes fear and redirects behaviors. Try a playful voice or simple game (like I spy) when they are scared.
- ✓ Food provided by a caregiver is an important part of feeling safe and building trust. Meals can be emotionally charged for children who have had bad experiences with food, who didn't have enough or may calm emotions.

What about Food and Water?

A well fed body is one key to how well a child can think, act, and learn.
Without enough healthy food and water, bodies, behaviors, and emotions are harder to control.

- Provide water and protein-rich snack or meal every 2 hours to balance blood sugar and keep brains working well. (Snacks are little meals, include 2-3 foods with protein, fat and carbs and sit together to eat them)
- Give choices you can say yes to. Choices give them control when so many things are out of their control.

Use these tips to help your child eat well. Keep track of what works best.

*Talk with your child's doctor if you have concerns about your child's growth or need more help with healthy food choices.

| What you might see: | What you can do: | What we have tried: <small>How did it work?</small> |
|-----------------------------|---|--|
| Temper tantrums around food | Sit together for meals and snacks (Use manners, be calm, patient and a good role model) | |
| | No TV or screens on while eating | |
| | Make meal time a fun and positive interaction (let them choose the color of plate) | |
| | Let them help (set the table or put silverware in the dishwasher) | |

Flip to the back for more tips

| What you might see: | What you can do: | What we have tried: <small>How did it work?</small> |
|------------------------|--|--|
| Food refusal | Do NOT force-feed or punish for not eating something (NO pressure) | |
| | Allow unlimited access to healthy foods (fruits and vegetables) | |
| | Offer 2 wanted foods and 1 non-favorite food at each meal (allow child to pick 1 food) | |
| | Respect their culture (ask what kinds of foods they are used to and offer familiar foods) | |
| | Trying to offer new foods without pressure (let them pick new foods to try at the store) | |
| Over eating | Offer plenty of water during the day (try to limit to only water between meals and snacks) | |
| | Avoid distractions while eating (allow focus on their body cues of being full) | |
| | Let them decide how much to eat from what is offered (Have the same meal choice for everyone) | |
| | Try to limit eating between meals and snack (offer sit down meals or snacks every 2-3 hours) | |
| Hording or hiding food | Restricting food does not work (and may cause more fears around food) | |
| | Rewards for "asking for food items" and "eating items when given" (instead of sneaking and hiding items) | |
| | Frequent checks for food in room and reward for bedroom free of foods | |
| | Do NOT shame or punish for hidden food (remind them they can ask for food items) | |
| | Keep healthy and high fiber snack options that you can say yes to when asked for (apples, carrot, pears, dried fruit, plain popcorn) | |

Find out more information at:

- Healthychildren.org
- [Be successful in feeding your adoptive or foster child \(elynsatterinstitute.org\)](http://Be successful in feeding your adoptive or foster child (elynsatterinstitute.org))
- childmind.org/resources
- Karyn Purvis Institute of child development: TBRI at child.tcu.edu/about-us/tbri

Figure A3

BITS for Toileting Behaviors

BITS: Behavioral Information Tip Sheets

Toileting behaviors for youth in foster care

Take a deep breath (Together if you can). Staying calm can help sooth fears and anxieties.

Trauma Lens: How is this harder for the child in my home?

Your child is doing the best that they can right now... It's our job to help them.

- Ask yourself...What is behind the behavior? Is there an unmet need my child has?
- Stay calm. Calm voice, calm face, calm body can help them calm down too.
- Be consistent and be predictable.

Brain and body response to trauma:

- Do they feel safe? Ask them? Feeling safe is different than being safe.

- ✓ Fear increases emotions and the fight or flight response making it hard for your child to listen and respond. Stress and trauma causes changes to the body's hormones that can lead to constipation, and accidents.
- ✓ Trauma can effect normal brain and body development leading to behaviors typical of younger children, including toileting behaviors. It can also cause backward steps in toilet training even after they are potty trained.
- ✓ Accidents, soiling and poop smearing may be a way of expressing feelings they don't how to show like anger or frustration, or may have become a way to protect themselves from unwanted physical contact.

What about toileting?

Understanding body signals and emotions are keys to improving toileting.
A child who has faced trauma may not recognize their body's cues to use the restroom.

- Teach them to **express their feelings.** Name feelings and talk about them (mad, sad, happy).
- Teach them to **listen to what their body is saying.** What do you feel when you need to use the toilet?
- Provide a **healthy diet, fluids and regular physical activity.** This helps the tummy function best.
- Do NOT shame or punish for accidents.** This won't change the behavior and can increase the problems.
- Talk with your child's healthcare provider. Toileting issues can have underlying medical causes that need addressed first.

Use these tips to help your child with toileting. Keep track of what works best.

| What you might see: | What you can do: | What we have tried: How did it work? |
|--|---|---|
| Constipation (Hard, dry, difficult or painful to get stools out. May go days without a bowel movement) | Sit and try to go everyday (best time is 20-30 min after the largest meal) | |
| | Sit right on the toilet (feet flat on a stool and knees above hips makes going easier) Relax and try for 10-15 min, but stay with them or close by for check-ins (books and bubbles can help relax and keep it fun) Drink water and eat a healthy diet (include fruits and veggies for fiber to keep stools soft) Daily Physical Activity (Keeps guts moving) Reward system, like stickers, for positive steps (reward for sitting and trying too!) | |
| Encopresis (liquid stools or smears in underwear, often caused by constipation) | Treat constipation first (Soiling can be a sign of stools leaking from too much in the colon) | |
| | Ease embarrassment (Use a codeword/ signal) | |
| Daytime urinary accidents (after being fully potty trained) | Address constipation first (full tummies push on the bladder!) | |
| | Drink water during the day (The bladder is a muscle and needs exercise by stretching/emptying) | |
| | Avoid caffeine (it can irritate the bladder) | |
| | Bathroom breaks every 2-3 hours | |
| | Relax to empty the bladder (Use a stool to rest feet on, take your time) | |
| Nighttime urinary accidents (Bed-wetting) | No drinks 1 hour before bed | |
| | Use the potty right before bed | |
| Smearing stools | Address clean up calmly | |
| | Provide sensory toys (Slime or playdough) | |
| | Keep clean up separate from normal fun bath time. (Use wipes or quick warm showers) | |

Find out more information at:

- www.eric.org.uk
- Healthychildren.org
- childmind.org/resources

Flip to the back for more tips

Appendix B

Survey Questions

Question for Encompass team to ask resource parents:

- Did you use a BITS tip sheet to help manage behaviors? y/n
Which sheet did you use? Sleeping/ Eating/ Toileting
- Were you made aware of the BITS sheets? y/n
- How helpful was the information on the BITS sheet? 1-5 (1 being not helpful and 5 being very helpful)
- Was it easy to access/find the sheet in the binders when you needed it? y/n
- Any other feedback you would like to give on the BITS tip sheets? _____

Question for Encompass team to answer:

- Is this resource parent the first placement in care? y/n
- Was the binder provided and reviewed with this resource parent? y/n
- Any other feedback you would like to give on the BITS tip sheets?

Additional data to track:

- How many notebooks with the BITS sheets were given out?

Appendix C

Implementing Knowledge Translation into Care Coordination Through KTA Model

