December 2019

Improving Healthcare Readiness to Respond to Human Trafficking: A Case Study

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IMPROVING HEALTHCARE READINESS TO RESPOND TO HUMAN TRAFFICKING: A CASE STUDY

A Dissertation
Presented to
the Graduate School of
Clemson University

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy
International Family and Community Studies

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by
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December 2019

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ABSTRACT

The purpose of this qualitative case study was to assess the readiness of a Department of Emergency Medicine (ED) to respond to human trafficking (HT), using an adapted Transtheoretical Model's Stage of Change Model as a guide. Content analysis allowed for an assessment of 13 system-wide policies and procedures and 25 hours of on-site observations of patient data collection processes and clinical practices during intake, triage, and the medical screening evaluation at three ED sites. Thematic analysis identified five readiness themes based on semi-structured interviews with 22 healthcare personnel from four ED sties. Results indicated that system-wide policies and procedures and patient data collection processes were at the precontemplative level of change across ED sites, meaning low levels of readiness to respond to HT. Clinical practice findings showed participants used their knowledge and expertise with other vulnerable patient populations to raise concerns about possible trafficked individuals seeking medical care, placing clinical practices at the contemplative level of change. Based on findings, recommendations to increase the ED's readiness to respond to HT included: mandating HT training for all ED personnel to enhance awareness, incorporating HT into current policies and procedures for vulnerable patient populations as well as creating a HT protocol that addresses a procedural work flow, enhancing patient data collection to include HT warning signs, identifying a consistent area to record suspicions in patients' medical records, and making community referral information readily available for staff. Future research with other EDs can apply the adapted TTM framework to determine the efficacy of this assessment model to assess HT readiness.

DEDICATION

To my loving and supportive family, I dedicate this dissertation to you. Without your encouragement, this long journey would not have been possible.

ACKNOWLEDGMENTS

Several gracious people helped me through the process of obtaining my PhD. First, I would like to thank Dr. Mark Small who patiently advised me throughout the doctoral program, and often with humor, especially as I unsuccessfully sought out organizations for my dissertation research. He provided the introduction to Dr. Ron Pirrallo, the Director of Emergency Medicine (ED) at Prisma Health, where I ended up conducting my research. A special thank you to Dr. Ron Pirrallo for taking an interest in my dissertation topic and to all the Prisma Health ED professionals who participated in the study. The insightful input from the ED staff will assist Prisma Health with enhancing its structure and systems to better respond to human trafficking in the near future. I also want to thank the faculty within the International Family and Community Studies program for their student-centered focus and encouragement throughout the doctoral process, including members of my committee (Drs. Bonnie Holaday, Natallia Sianko, Arelis Moore de Peralta, and Amy Ramsay) for sharing their expertise and helping when necessary. Finally, a heart-felt thanks to Dr. Lynn McMillan for her friendship and support as well as to Dr. Arlene Andrews and Dr. DeAnne Hilfinger Messias for believing in me.

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CHAPTER ONE

INTRODUCTION

Human trafficking (HT) is a human rights crime affecting men, women, children, and communities throughout the world (Office of Trafficking in Persons, 2017). As a result of the inherent violence as well as the unsafe living and working conditions of this crime, health repercussions for survivors are complex and varied (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Greenbaum, 2016; Lederer & Wetzel, 2014; Polaris, 2018; Restore, 2019; Shandro, Chisolm-Straker, Duber, Findlay, Munox, Schmitz, Stanzer, Stoklosa, Wiener, & Wingkun, 2016), and therefore, requires healthcare facility readiness to effectively respond to survivors seeking medical care.

Human trafficking is a crime, whereby criminals known as human traffickers, force, coerce, or provide fraudulent information with the primary intent of exploiting individuals sexually and/or through forced labor. The terms “human trafficking” and “trafficking in persons” are umbrella phrases used for the act of recruiting, harboring, transporting, providing, or obtaining persons for exploitation (U.S. Department of State, 2013). Despite the term trafficking, the act of trafficking a person does not require smuggling or movement of the victim (U.S. Department of Justice, 2013). Persons may be trafficked within their own communities, within country borders, or across international borders.

On October 28, 2000, the United States Congress passed the Trafficking Victims Protection Act of 2000 (TVPA). This piece of legislation was the first comprehensive

law to address trafficking in persons and was reauthorized in 2003, 2005, 2008, and 2013. The TVPA defined "severe forms of trafficking" in persons as:

a) "The recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act where such an act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age, or
b) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery" (TVPA, 2000, p. 8).

World-wide, the International Labour Organization (2019) estimated that 40.3 persons were trafficked in 2016. In the United States (U.S.), however, reliable statistics on the prevalence of HT are limited. The U.S. Department of State (2018) does report that U.S. is a source, transit, and destination country for human trafficking that consists of U.S. citizens and foreign nationals who are subjected to this crime. The most reliable source of documented human trafficking cases in the U.S. is the National Human Trafficking Resources Center (NHTRC). The NHTRC has collected data on human trafficking cases since 2007. From 2007 to 2018, NHTRC reported 45,308 cases across the country.

In addition to be being a violent crime, HT also is recognized as a public health problem (American Nurses Association, 2010; Office on Trafficking in Persons, 2017; Zimmerman & Kiss, 2017). Research shows that trafficked individuals are exposed to

numerous health complications (Kiss & Zimmerman, 2019; Lederer & Wetzel, 2014; Oram, Stöckl, Busza, Howard, & Zimmerman, 2012) and are seeking medical care during their exploitation (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Chisolm-Straker, Baldwin, Gaïgbé-Togbé , Ndukwe, Johnson, & Richardson, 2016; Lederer &Wetzel, 2014; Polaris, 2018). Despite this knowledge, limited research exists on the readiness of healthcare settings to identify and treat survivors.

This qualitative case study aimed to provide an in-depth assessment on the readiness of a department of emergency medicine for a large hospital system in the Upstate of South Carolina to respond to HT. Understanding healthcare readiness is critical for enhancing standards of care for trafficked individuals and increasing intervention efforts. This study demonstrated the importance of incorporating human trafficking into policies and procedures, patient data collection processes, and clinical practice methods to improve readiness levels in emergency room settings.

Statement of Problem

Hospitals across the country are becoming more aware of HT in their respective communities and are beginning to take steps to increase response efforts through human trafficking protocols (Genesee County Medical Society, n.d.; Massachusetts General Hospital and Massachusetts Medical Society, 2014). Yet, research indicates that healthcare settings, in general, is unprepared to respond to trafficked individuals because of a systematic lack of awareness (Armstrong, Greenbaum, Lopez & Barroso, 2019; Greenbaum, 2016; Egyud, Stephens, Swanson-Bieman, DiCuccio & Whiteman, 2017;

Shandro, Chisolm-Straker, Duber, Findlay, Munoz, Schmitz, Stanzer, Stoklosa, Wiener, & Wingkun, 2016).

South Carolina is not immune to HT. At present, South Carolina does not have a HT data collection system; therefore, data on the prevalence of HT is limited (South Carolina Human Trafficking Task Force, 2018). The main source of human trafficking information for the state is the NHTRC database. According to NHTRC, South Carolina has had 531 reported cases from 2007 to 2018. In 2018, for example, NHTRC documented 81 cases that consisted of 56 sex trafficking, 18 labor trafficking, 5 sex and labor trafficking, and 2 unspecified cases. NHTRC does not provide specific geographic details as to where the cases were in the state.

The Upstate of South Carolina, where this study was conducted, is located in the Southwest region of the state. This region is between two well-known hubs of HT activity, Atlanta, GA and Charlotte, NC.

In terms of healthcare, limited research exists on the readiness of healthcare settings, and specifically emergency departments, to respond to human trafficking. In 2014, the South Carolina Human Trafficking Task Force released its first report on how to address this crime. One of the findings was that medical professionals were not trained to recognize signs of human trafficking. This lack of awareness has impeded the identification of trafficked individuals accessing medical care in the state. In January 2019, the state offered its first HT training to healthcare professionals (South Carolina Human Trafficking Task Force, 2018). Hence, South Carolina recognizes the deficiencies

in HT awareness in medical settings and is beginning to address the issue with healthcare professionals.

In a state-wide study of South Carolina hospitals, researchers found that 72% of healthcare professionals believed they had cared for trafficked individuals and four participants treated victims of sex trafficking (Armstrong, Greenbaum, Lopez & Barroso, 2019). Therefore, it is likely that trafficked persons are accessing medical care through emergency rooms in the Upstate of South Carolina. These researchers also indicated that hospitals in South Carolina are underprepared to respond to human trafficking. Some of the recommendations for South Carolina hospitals included developing and implementing HT policies and procedures, training healthcare professional on warning signs, and ensuring the safety of confirmed or suspected trafficked individuals.

Purpose of the Study

The U. S. Department of State (2017) stressed that human trafficking is a public health issue. In the 2017 Trafficking in Persons Report, the U. S. Department of State recommended a public health perspective to develop effective prevention strategies and to support survivors. The aim of this study was to address the research gap in the literature on healthcare readiness to respond to human trafficking. This qualitative case study assessed the readiness for change of Prisma Health's Department of Emergency Medicine (ED) to identify and respond to trafficked individuals. Specifically, the research objectives were to: 1) provide an organizing framework to understand the readiness of the ED's systems to respond to human trafficking, using the Transtheoretical Model's (TTM) stages of change construct, 2) explain the readiness of the ED across sites and within its

systems, and 3) develop recommendations to enhance the ED's readiness to respond to HT.

To assess the readiness of the ED's systems, a three-pronged contextual approach was used that consisted of key ED policies and procedures, standardized patient data collection processes as well as clinical practice methods. First, organizational policies are a statement of intent and provide a course of action for personnel. The ED has several policies and procedures that focus on vulnerable patient populations that present with issues, such as sexual assault, domestic violence, and substance abuse. These issues may intersect with HT. Second, the ED collects standardized patient data during patient in-take, triage, and the medical evaluation. The examination of data included what information was asked of patients and whether human trafficking indicators were part of the data collection process as well as when in the process data is collected and how it is shared in the electronic medical records. Third, the analysis of clinical practice methods showed how ED policies and procedures were implemented and healthcare professionals' perceptions of the capability of the ED's current systems to effectively identify and treat trafficked individuals.

The presentation of this case study begins with the context of health-related complications for trafficked individuals and the need for increased readiness of healthcare settings to improve response efforts. Next is an explanation of the methods used to carry out the study, followed by the analysis of ED data collected with the assistance of the Transtheoretical Model stages of change to determine readiness levels. Finally, findings from this study reinforce the need for additional research on healthcare

readiness and demonstrate a number of implications for more effective healthcare policy and practice methods.

CHAPTER TWO

LITERATURE REVIEW

Over the past decade, human trafficking research focused heavily on describing the various forms of this crime as well as descriptive characteristics of exploiters and those being exploited. These studies were important in helping to understand the nature of this crime, the perpetrators, and its victims. Underrepresented in the first generation of human trafficking research were health-related studies (Sweileh, 2018). Researchers contend that the second generation of human trafficking research needs to focus, in part, on health issues of sex and labor trafficked individuals as well as healthcare prevention and intervention efforts (Kiss & Zimmerman, 2019; Sweileh, 2018).

The present body of literature on the intersection between healthcare and human trafficking demonstrates the need for an improved systematic response by healthcare settings. Current research provides evidence of trafficked individuals seeking medical care for health-related issues that occur during and after exploitation, and ways for healthcare settings to increase the identification of human trafficking. The American College of Emergency Physicians (ACEP) developed a policy statement in 2016 that stated, “Because victims of trafficking seek medical attention for acute injuries and illnesses as well as neglected chronic conditions, emergency clinicians are in a unique position to assess, intervene, and refer for assistance” (p. 1).

Accessing Medical Care

Research is beginning to demonstrate that trafficked persons are seeking medical care as a result of health consequences associated with human trafficking (ACEP, 2016;

Baldwin et al., 2011; Chisolm-Straker et al., 2016; Lederer &Wetzel, 2014; Mostajabian, Maria, Wiemann, Newlin, & Bocchini, 2019; Polaris, 2018). For example, in a study that focused on survivors' encounters with healthcare settings, Baldwin et al. (2011), reported that 50% (n=6) visited a healthcare facility or a physician while being trafficked. In general, survivors indicated that they visited a range of healthcare settings from small, private facilities to large, public hospitals. Lederer and Wetzel (2014) found that 88% of survivors (n=98) had contact with a healthcare provider while being trafficked and 63% sought treatment from a hospital/ER. In 2016, Chisolm-Straker et al., conducted a retrospective study of survivors and noted that 68% (n=117) were seen by a healthcare provider. Many survivors (56%) reported a visit to an emergency room or urgent care center. Specific to sex trafficked minors, Goldberg, Moore, Houck, Kaplan, & Barron (2017) discovered that 49% of youth patients sought medical care one to three times, while 9% required medical attention more than eight times.

Restore NYC (2010), a nonprofit organization that assists foreign-national survivors, conducted a study on healthcare access (n=76). Participants included sex and labor trafficking survivors. Among the participants, 37% accessed healthcare. Findings showed that participants (n=28) accessed various types of healthcare facilities with primary care being most likely (50%) and followed by OB/GYN (46%) and then emergency departments (29%). Moreover, participants (n=25) were likely to access services two to five times (36%) and the most common reason for seeking treatment was for sexual/reproductive/STDs (43%).

Similar to the Restore NYC (2010) study, Polaris (2018) found that survivors of sex and labor trafficking accessed healthcare services for different medical issues with emergency medical and pediatric care issues being the most prominent, followed by reproductive health problems. A survey of 127 survivors showed that 69% of respondents accessed healthcare while being trafficked and 85% indicated that medical issues were caused by their exploitation. Respondents also reported (57%) that they were never asked questions related to trafficking or abuse, but they did receive dismissive or insensitive comments and questions from emergency healthcare professionals who were caring for them.

These studies show that trafficked persons are accessing medical services but are rarely being identified. Restore NYC (2019) found that two participants were identified by a healthcare professional. Increased awareness of medical indicators for trafficked persons is critical for healthcare professionals to increase human trafficking identification.

Health-Related Consequences

Human trafficking is fraught with healthcare consequences for survivors. Often, health issues for trafficked persons are the result of inhumane conditions, such as physical, sexual, and emotional attacks by traffickers, poor sanitation, inadequate nutrition, poor personal hygiene and dangerous workplace environments (DHHS, n.d.; Oram et al., 2012). At present, knowledge about human trafficking and its health-related issues, primarily comes from research on sex trafficking (Graham, Macy, Eckhardt, Rizo, & Jordan, 2019). In a systematic review of the literature by Graham et al., (2019), the

researchers noted that among the 53 studies reviewed, 46 were focused on survivors of sex trafficking, six on labor or sex, and one did not clearly define the type of trafficking. Since limited information exists on the health issues of labor trafficking, the proceeding discussion on health-related issues affecting survivors and how to identify trafficked persons in healthcare settings, is mainly derived from studies on sex trafficking. Polaris (2018) also indicated that education materials are available for healthcare providers to spot human trafficking red flags; however, this information is based on sex trafficking. "…similar resources related to potential labor trafficking are either not available or extremely limited in scope" (p. 38).

Despite the gap in the literature about labor trafficking, the health-related evidence that is available will assist healthcare settings to increase their response to human trafficking through improved infrastructure. Evidence shows that the health-related consequences of human trafficking result in long-term problems for adult and youth survivors (Baldwin, Fehrenbacher, & Eisenman, 2015; Polaris, 2018). For example, Baldwin, Fehrenbacher, and Eisenman (2015) found that "…psychological abuse creates extreme stress that can lead to acute and chronic, physical and mental health problems" (p. 1171).

In general, research has shown how traumatizing trafficking-related experiences are on survivors physical and mental well-being (Goldberg et al., 2017; Lederer & Wetzel, 2014; Restore NYC, 2019). The Federal Bureau of Investigation reports that human sex trafficking, in particular, is becoming more violent and organized (Walker-Rodriguez &

Hill, 2013). The increased violence will likely lead to more health-related problems, causing more trafficked individuals to seek medical care.

Physical Health Issues

The toll of human trafficking often leads to physical health complications for trafficked individuals. Research highlights the number of physical health symptoms from injuries to malnutrition to neurological symptoms (Lederer & Wetzel, 2014; NHTRC, 2019; Restore NYC, 2019; Shandro et al., 2016). Lederer and Wetzel (2014) found that 99% of their respondents had a least one physical health issue during their exploitation. Neurological problems, such as memory issues, insomnia, or poor concentration were the most frequently reported physical issues.

Another common health concern for trafficked individuals accessing medical care are physical injuries (Goldberg et al., 2017; Lederer & Wetzel, 2014; Restore NYC, 2019). According to Lederer and Wetzel (2014), 70% of respondents had injuries to their head or face. Other studies showed that 21% of adult respondents sought treatment for physical injuries (Restore NYC, 2019) and 9% of minors' chief complaints were physical injuries as well (Goldberg et al, 2017).

Mental Health Concerns

The traumatic experiences of human trafficking cause or exacerbate mental health issues for trafficked individuals. The powerful, nonphysical coercive tactics used by traffickers, such as threats, degradation, and isolation, cause enormous stress for trafficked individuals and reduces their ability to cope (Baldwin, Fehrenbacher, & Eisenman, 2015). Survivors who sought medical treatment for mental health

complications is documented in several studies (Baldwin, Fehrenbacher, & Eisenman, 2015; Goldberg et al., 2017; Lederer & Wetzel, 2014; Restore NYC, 2019).

Lederer and Wetzel (2014) stressed that the brutal treatment endured by trafficked individuals creates ongoing mental health conditions. Their study demonstrates the long-term effect of human trafficking. Among their respondents, 98% had at least one psychological issue during exploitation and 96% afterwards. While being trafficked, the main mental health issues consisted of depression (89%), flashbacks (68%), shame/guilt (82%), post-traumatic stress disorder (PTSD) (55%), and attempted suicide (42%). After exploitation, respondents still reported issues in each category, although the percentages decreased with the exception of PTSD, which increased by 21%. Restore (2019) also indicated that 22% of its respondents required medical treatment for mental health, although specific psychological categories are not provided.

As for trafficked minors, many of them experience a myriad of mental health issues because of abuse and neglect prior to being trafficked along with being subjected to human trafficking (Greenbaum, 2016; Goldberg et al., 2017; Smith, Varadam, & Snow, 2009; U.S Department of Health and Human Services, 2013). Psychological consequences for DMST survivors include low self-esteem, social ostracism, dislocation from family (U.S. Department of State, 2012) as well as a host of mental health disorders, such as PTSD, anxiety and stress disorders, developmental disorders, eating disorders, and mood and personality disorders to name but a few (Smith, Vardaman, & Snow, 2009).

In a study that focused on a retrospective analysis of 41 medical records for patients referred for DMST evaluation, researchers found psychiatric issues were the most frequent medical complaint of minors (Goldberg et al., 2017). Medical histories revealed that 46% of patients had previous psychiatric admissions and 66% had a psychiatric diagnosis. Confirming the reduced coping ability of trafficked individuals, as reported by Baldwin, Fehrenbacher, & Eisenman (2015), 59% of the minor patients had suicidal ideation and 44% had self-injurious behavior. These findings show the complex mental health histories of trafficked youth.

Sexual Health Issues

Sexual health issues are yet another consequence for trafficked individuals. Traffickers often exert control over reproductive health by prohibiting condom use or insisting on other types of birth control methods (Polaris, 2018). The lack of protection during sexual exploitation increases the risk of sexually transmitted infections (STIs), human immunodeficiency virus (HIV), and unintended pregnancies (Baldwin et al., 2011; Goldberg et al., 2017; Lederer & Wetzel, 2014; Restore NYC, 2019). More than two-thirds of the female respondents in Lederer and Wetzel's study contracted an STI while being trafficked.

Trafficked individuals seek medical care as a result of sexual health issues. Restore NYC (2019) found that 43% of respondents sought medical treatment for sexual/reproductive/STIs. Researchers did not provide a breakdown of the sexual health categories or where respondent's went for medical care.

The nature of human trafficking increases the sexual health risks to trafficked youth as well. Youth are likely to contract STIs (Goldberg et al., 2016; Gragg, Petta, Bernstein, Eisen, & Quinn, 2007; Hickle & Roe-Sepowitz, 2018) and HIV/AIDS (Goldberg et al., 2016; Gragg et al., 2007). Results from Goldberg et al., (2017) showed that youth involved in DMST had several sexual health problems. Youth medical records indicated that 22% had an STI and 2% had more than one type. Medication was given for other sexual health-related problems, such as HIV postexposure prophylaxis (22%) and pregnancy prophylaxis (24%). When asked about condom use, 34% of youth reported that they used condoms sometimes.

Substance Abuse Problems

As a means of exerting control over an individual, a trafficker might force or coerce the use of drugs and alcohol (DHHS, n.d.; Goldberg et al., 2016; Hickle & Roe-Sepowitz, 2018; Lederer & Wetzel, 2014; Polaris, 2018; Raphael, Reichert, & Powers, 2010). Control through the use of drugs and alcohol helps to ensure compliance over adults and minors (Lederer & Wetzel, 2014; Polaris, 2018; Raphael, Reichert, & Powers, 2010). Based on NHTRC data since 2015, 2,853 potential victims (12%) indicated that they had drugs or alcohol used against them during their exploitation (Polaris, 2018). Most of these potential victims (88%) were trafficked for commercial sex purposes. Furthermore, the abuse of substances might be used as a coping mechanism during as well as after exploitation (Lederer & Wetzel, 2014). Substance abuse, therefore, becomes another health obstacle for survivors to overcome.

Healthcare professionals need to be aware that substance abuse might intersect with human trafficking. Lederer and Wetzel's (2014) findings showed that 84% of respondents had a substance abuse problem with alcohol, marijuana, and cocaine being the most prevalent sources. Among minors, Goldberg et al., (2017) noted that 88% had used alcohol or substances. The most common used substance was marijuana, followed by cocaine and then alcohol. Like some adult survivors, minors used drugs to lessen the psychological effects of their exploitation.

Moreover, substance abuse use might be a pre-existing health issue for individuals trafficked for sex and labor purposes. According to Polaris (2018), traffickers prey on individuals with substance abuse problems and other health issues, such as disabilities and mental health. Substance use was the most common pre-existing health concern for sex trafficked individuals. For survivors of labor trafficking, substance abuse was the third highest pre-existing health concern and was preceded by physical disability and mental health.

Prior Histories

Over the past decade, research has shown prior histories of child welfare involvement, prior abuse or neglect, and runaway histories for trafficked youth (Gibbs, Henninger, Tueller, Kluckman, 2018; Gragg et al., 2007; Goldberg et al., 2017; Hickle & Roe-Sepowitz, 2018; Walker-Rodriquez & Hill, 2013). Patient data collection that includes prior histories is needed in healthcare settings to assist with the identification of trafficked youth. A history of child welfare involvement is a possible red flag. As Gibbs et al., (2018) demonstrated, trafficked youth in child welfare were twice as likely to have

experienced prior maltreatment compared to non-trafficked youth and 10 times as likely to have run away from placement.

In a New York State Office of Children and Family Services study of eleven counties, including 159 agencies that work with trafficked youth, findings suggested that 85% (n=253 for NYC and n=399 for the Upstate) of trafficked youth had prior child welfare involvement because of child abuse and neglect allegations (Gragg et al, 2007). A substantial proportion had prior foster care placement (75% for NYC and 44% for Upstate NYC). In many cases, the youth had experienced psychological or physical trauma from family members.

Similar to Gibbs et al., (2018) and Gragg et al., (2007), Goldberg et al., (2017) reported histories of child welfare involvement (42%), running away (63%), and exposure to child maltreatment (90%) for pediatric patients referred for DMST evaluation. A range of child maltreatment exposure was reported with the most common form being parental substance abuse (59%), followed by sexual abuse (57%).

Moreover, Hickle and Roe-Sepowitz (2018) confirmed Gibbs et al., (2018), Gragg et al., (2007) and Goldberg et al., (2018) findings of exposure to child maltreatment in their study of girls in residential care. In a comparative study between trafficked youth and non-trafficked youth in residential care, the researchers found that trafficked youth were more likely to experience child sexual abuse. Like runaway history shown in studies by Gibbs et al., (2018) and Goldberg et al., (2017), trafficked youth were more likely than non-trafficked youth to run away from residential care.

Tattoos

In addition to specific health-related issues, tattoos are potential indicators of human trafficking (Goldberg et al., 2017; Greenbaum, 2016; Fang, Coverdale, Nguyen, & Gordon, 2018; NHTRC, 2019; Shandro et al., 2016). As part of the traffickers' arsenal of control, tattoos are used to mark trafficked individuals, especially in sex trafficking (NHTRC, 2019). In Goldberg et al., (2017), 21% of the trafficked youth had tattoos, although it was not reported if these markings were by traffickers.

In NHTRC (2019) list of human trafficking red flags and indicators for healthcare settings, tattoos are in the sex trafficking indicator category. These tattoos might say, "For Sale," "Daddy," or "Property of..." Fang, Coverdale, Nguyen, and Gordon (2018) conducted one of the few studies on tattoos used by traffickers and provided a more in-depth understanding of the types of tattoos used than NHTRC. They analyzed photographs of tattoos on identified trafficked persons and found a number of tattoo types, such as traffickers' names to show ownership. A range of symbols also were used, like "$," "ATM," and crowns as well as profanity. The researchers noted that some tattoos were professional-grade, while others were homemade.

Tattoos, therefore, are another possible human trafficking indicator for healthcare professionals to be aware of when screening for vulnerable patients. As part of the overall improved response to human trafficking in healthcare settings, healthcare professionals should be educated on tattoos used for branding purposes. A visual screen by healthcare professional might aid in the identification of trafficked individuals (Fang, Coverdale,

Nguyen, & Gordon, 2018). Shandro et al., (2016) recommended the documentation of tattoos during the physical examinmation.

Healthcare Readiness

Research shows that healthcare providers are in a unique position of interacting with trafficked individuals seeking medical care (Dovvdaitis, 2010), and therefore, serve an important role in a healthcare response to human trafficking (Greenbaum, 2016; Hachey & Phillippi, 2017).

However, a major barrier of human trafficking identification is the lack of awareness and training of healthcare providers (Beck, Lineer, Melzer-Lange, Simpson, Nugent, & Rabbitt, 2015; Dovydaitis, 2010; Goldberg, Moore, Houck, Kaplan, & Barron, 2016; Hachey & Phillippi, 2017; Institute of Medicine & National Research Council (IMO/NRC), 2013; Recknor, Gemeinhardt, & Selwyn, 2018). On December 31, 2018, President Trump signed into law the SOAR (Stop, Observe, Ask, and Respond) to Health and Wellness Act of 2018 (GovTrack.us, 2019). This law allowed the U.S. Department of Health and Human Services to develop training programs for healthcare and social service providers, making HT awareness a priority.

Since trafficked individuals rarely self-identify, it is incumbent upon healthcare professionals to recognize warning signs of human trafficking. A study about medical professionals' awareness of human trafficking by Titchen, Loo, Berdan, Rysavy, Ng, & Sharif (2017) found a need for standardized human trafficking education. Results from their study demonstrated that while physicians and medical trainees believed that knowledge on human trafficking was critical to their practice, they were unaware of the

magnitude of human trafficking and how to report a concern. A study by Mostajabian et al. (2019) found that exploited youth seek medical care but are often not being identified during the medical screening process. Youth reported mistrust of healthcare providers and this resulted in low disclosure of exploitation.

Education of healthcare professionals is essential for increasing awareness and changing practice to respond to human trafficking. One study, conducted at a level 2 trauma center in southwestern Pennsylvania, implemented a project to improve the identification and rescue of trafficked persons (Egyud et al., 2017). Participants completed mandatory education on human trafficking that consisted of screening tools, medical red flags, resources, and plans on notifying appropriate community agencies for follow up services. Post-education survey results indicated that 97% of participants were committed to change practice. Findings also showed that 74% agreed that the education program improved their competence and 75% intended to use different communication techniques to better identify trafficked persons.

On December 31, 2018, the SOAR to Health and Wellness Act of 2018 became law (GovTrack.us, 2019). This law authorizes the Stop, Observe, Ask, and Respond (SOAR) to Health and Wellness Training Program for healthcare and social service professionals. The Department of Health and Human Services will develop and implement the comprehensive training program with a budget of $4 million per FY 2020-2024 (Office on Trafficking in Persons, 2018). The law's focus on training healthcare professionals about human trafficking will help to increase awareness, thereby reducing a major barrier to identifying trafficked individuals in healthcare settings.

Despite a growing awareness of HT among healthcare professionals, research remains limited on how this awareness creates systematic change within healthcare facilities to respond to trafficked individuals (Armstrong, Greenbaum, Lopez, & Barroso, 2019; Baldwin et al., 2011; Recknor, Gemeinhardt, & Selwyn, 2018). "Systematic factors, including a lack of infrastructure, to meet the needs of human trafficking survivors, also affect engagement" (Judge, Murphy, Hidalgo, & Macias-Konstantopoulos, 2018, p. 660). Furthermore, the overall lack of awareness and research within healthcare settings has created barriers in the development of adaptable models of care for effective healthcare delivery to trafficked persons (Judge, Murphy, Hidalgo, & Macias-Konstantopoulos, 2018).

Summary of Past Literature and Significance of Current Study

Human trafficking is a public health issue that requires a comprehension, systematic response from healthcare settings to identify and treat trafficked persons. Trafficked persons are accessing healthcare settings, including emergency rooms, as a result of human trafficking health-related consequences. Health issues consist of physical, psychological, and substance abuse problems that might have pre-existed to exploitation or occurred during the trafficking experience. Researchers have identified some health issues as potential human trafficking indictors as well as prior histories, like child welfare involvement, and tattoos.

Moreover, studies showed the necessary steps that healthcare settings need to take to enhance response efforts. A priority for healthcare settings is to increase awareness of human trafficking warning signs among healthcare professionals. A significant step to

enhancing healthcare professional's readiness to identify and effectively treat trafficked persons across the country is the passage of the SOAR to Health and Wellness Act of 2018. Healthcare professional awareness will likely translate to systematic improvements in healthcare settings.

Systematic improvements are necessary for a consistent, effective response. It is critical, therefore, that healthcare settings establish human trafficking protocols to shore up organizational infrastructure. In 2016, the ACEP put forth a list of recommendation that called for protocols to address HT, ongoing training and education of healthcare personnel, and survival-centered, trauma-informed approaches to care.

This study filled the gap in the literature about how healthcare settings can systematically improve efforts to respond to human trafficking. Specifically, it demonstrated the readiness for change of an ED's current systems to identify and treat trafficked individuals and provided recommendations on how to systematically improve its response across the ED's catchment area. The conceptual framework used in this study to assess the ED's readiness might also be used by other healthcare settings for more effective responses to trafficked individuals seeking emergency medical services.

Conceptual Framework

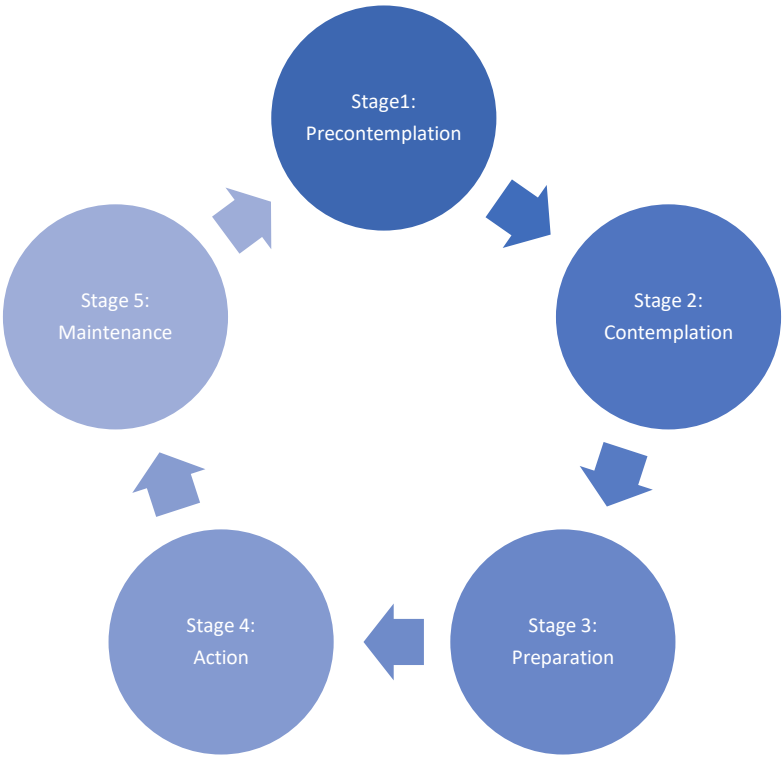
The transtheoretical model (TTM) or stages of change model (Prochaska, Prochaska, & Levesque, 2001) provided an organizing framework to assess the current readiness capacity of the ED to respond to human trafficking. Prochaska and Norcross (1994) originally developed TTM to explain individual health behavior change. In 2001,

Prochaska, Procahaska, & Levesque suggested that the TTM could serve as an integrative framework to changing organizations. Today, the TTM is a widely used model of health behavior change at the individual and organizational level.

In recent years, research has been conducted on organizational readiness, using the TTM (Berry, Plotnikoff, Raine, Anderson, & Naylor, 2007; Davis, Corr, Gilson, Ting, Ummer-Christian, & Cook, 2015; Tyler & Tyler, 2006). Central to the TTM is the stage of change construct (Prochaska, Prochaska, & Levesque, 2001). The TTM suggests that behavior change progresses through a series of five stages that include precontemplation (not intending to take action), contemplation (intending to make change but not immediately), preparation (intending to take action in next 30 days), action (made changes in last 6 months), and maintenance (made changes more than 6 months ago). Organizations begin the process of change through the precontemplation stage but may recycle through latter stages since change is not a linear process. Time needed in each stage may vary, depending on factors, such as the complexity of the organization. Figure 2.1 shows how change evolves within an organization, according to Prochaska, Prochaska, and Levesque (2001).

Figure 2.1

Transtheoretical Model of Change



TTM Criticism

The TTM has received some criticism, specifically that the boundaries between stages are unclear, making it difficult to assign a discrete stage of change to an individual or organization (Littrell & Girvin, 2002; Tyler & Tyler, 2006). Another critique is that the stage of change construct, when applied to an organization, be described as perceived organizational readiness (Berry et al., 2007). Berry et al., (2007) also recommended qualitative interviews or focus groups to fully understand staff's perceptions of readiness

within an organization. Semi-structured interviews with ED personnel was one of the methods used for this study. Despite the criticism, the stage of change construct provided an initial understanding of readiness for a healthcare setting. As a result of the complexity of a healthcare setting, it is acknowledged that different stages might exist within the organization, depending on the system being assessed.

Stages of Change and Human Trafficking

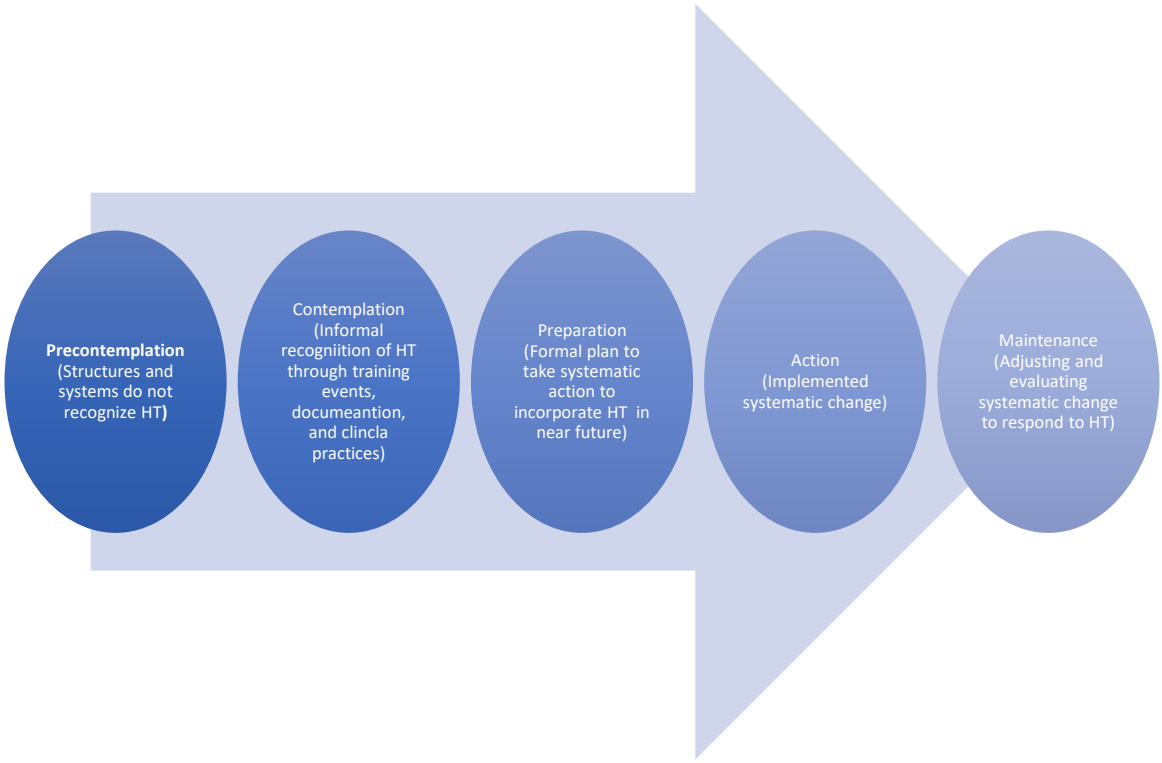
Through a partnership between two leading human trafficking organizations, Health, Education, Advocacy, Linkage (HEAL) Network and Hope for Justice (2017) created a protocol toolkit for healthcare settings to develop a trauma-informed response to assist trafficked individuals seeking medical care. The recommendations for developing a human trafficking response, as outlined in the protocol and in concert with the TTM framework, acted as a guide to determine the ED's readiness.

Figure 4.1 is a model of the TTM Stage of Change, adapted from Prochaska, Prochaska, and Levesque's (2001) approach to changing organizations. The model was adapted by the researcher to feature a HT response within the ED's structure and systems. Systematic action/change is related to policies and procedures, data collection processes, and clinical practices. Another adaptation from the original model is a linear process rather than cyclical process because once the ED begins to implement change, the goal is to move toward maintenance. Once the ED reaches the maintenance stage within its structure and systems, awareness of a HT response is achieved and allows for the identification and response to trafficked individuals. In the adapted model, the final stage

of change, maintenance, now includes evaluation to ensure the effectiveness of the systemic change. Furthermore, the timeframes listed in Prochaska, Prochaska, and Levesque's (2001) model are eliminated in the adapted model as a result of the complexity of the ED's structure and systems, along with resource and time constraints.

Figure 2.2

Transtheoretical Model of Change Adapted from Prochaska, Prochaska, & Levesque (2001) to show change within ED.



Stage One: Precontemplation

In the stage of precontemplation, healthcare settings are not considering how their policies and procedures, data collection processes, and clinical practices might assist in identifying human trafficking. At this stage, the organization's structure and systems are not ready to effectively respond to human trafficking. Limited awareness of human trafficking among all staff categories prevents the identification of trafficked individuals.

Stage Two: Contemplation

The stage of contemplation suggests that a healthcare setting is taking informal steps to recognize HT. Growing awareness about HT may result in discussions about policy and procedure changes, training needs to enhance awareness, and more effective data collection processes. Staff within the healthcare setting are becoming aware of the issue and taking informal action, such as hosting a training and inviting community experts to talk about HT in staff meetings.

Stage Three: Preparation

The healthcare setting is moving toward the stage of preparation when it is committed to the change process. An example of this stage might be deciding to develop an HT protocol to help guide ED personnel with suspected HT cases. Another example might be leadership deciding to form a committee to review current policies and procedures to determine how to integrate a HT response. This stage would consist of any efforts the healthcare setting is taking to proactively prepare for the identification and treatment of trafficked individuals.

Stage Four: Action

The stage of action occurs when the healthcare setting is actively engaged in making changes to its structure and systems. In this stage, the organization might have mandated HT training events to enhance staff awareness and to clarify roles and HT reporting procedures. Changes are being made to policies and procedures to systematically enhance identification as well as treatment responses. The organization might take steps to maximize patient and staff safety. Additionally, data collection might include HT screening questions to assist with identification. Furthermore, standardized data collection is essential to understanding the prevalence of trafficking in a geographic location.

Stage Five: Maintenance

In the final TTM stage of maintenance, the healthcare setting has developed clear policies and procedures that address HT, improved its data collection processes to better identify and treat trafficked persons, and/or enhanced clinical practice modalities that include a trauma-informed response. This stage requires on-going monitoring and evaluation to ensure that change is being implemented as required. Based on evaluation findings, adjustments might be made to ensure continued progress with the organization's response.

Summary of Conceptual Framework

An adaptation of TTM Stage of Change model acted as the organizing framework to assess the ED's readiness to respond to HT. In the adapted model for this study, a linear

process of the five stages of change showed the evolution of the ED's structure and systems, moving from precontemplation (not recognizing HT) to maintenance and evaluation of systematic change to respond to HT. Eliminated from the adapted model were timeframes for change as a result of the complexity of a large hospital system, covering a wide catchment area in the Upstate of South Carolina.

During the investigation of the ED's structure and systems, the researcher used the adapted TTM's Stage of Change model to ascertain readiness levels. The next section will discuss the study's method for an in-depth analysis of the ED's readiness to respond to HT.

CHAPTER THREE

METHOD

The current study uses a qualitative case study approach to assess the ED's readiness to respond to human trafficking. The intent of the case study design was to garner an in-depth assessment of the ED's current structure and systems. The primary research questions were:

1. What is the readiness for change within the ED's systems to respond to HT that include policies and procedures, patient data collection, and clinical practices?
2. What is the readiness for change within the ED's systems to respond to HT across ED sites?
3. How does system readiness vary across ED sites?
4. How does system readiness for change to respond to HT vary based on perceptions of ED healthcare professionals in different job categories?

Design

A case study approach assisted in determining the readiness of the ED's current structure and systems to effectively respond to HT. To gain insight into multiple systems and assess them effectively, the use of a case study design is a favorable method (Yin, 1999). According to Yin (2014), "a case study is an empirical inquiry that investigates a contemporary phenomenon (the "case") in depth and within its's real-world content" (p. 16). Yin (2014) further stipulates that case study research relies on the triangulation of multiple sources of evidence. Therefore, this study used the case study approach for an in-depth assessment of the ED's readiness to respond to trafficked individuals across systems and sites, using multiple sources of evidence.

Case Study Database

A computer file on a password protected computer, along with the qualitative software program, ATLAS. ti 8 (2016), assisted with organizing and documenting data collected from different sources at ED sites. A locked filing cabinet housed hard copies of ED system-wide policies and procedures used for the study, field notes as well as participant consent forms for semi-structured interviews. Maintaining a case study database allows for the inspection of data collected, thereby increasing the reliability of the case study (Yin, 2014). Contents in the computer database included memos, field notes, interview transcripts, and patient data collection Excel spreadsheets for triage and medical screening evaluation observations.

Case Study Chain of Evidence

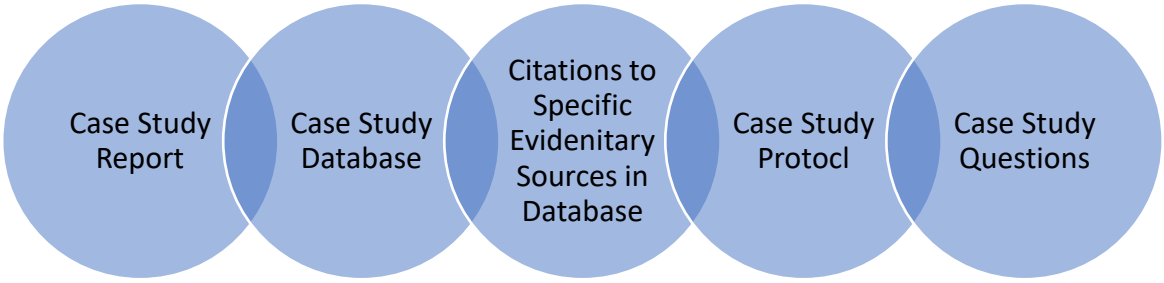
Maintaining a chain of evidence was another important step in the data collection process as well as a method to increase the reliability of information (Yin, 2009). Similar to a forensic investigation, this step would allow an external observer to trace the steps of the investigation from the beginning of the study to its conclusion and vice versa (see Figure 3.1). By demonstrating consistent data collection with each case through the chain of evidence process, construct validity increased as did the overall quality of the study.

The case study database contained data collected during the policy and procedure review, the patient data collection processes as well as transcripts from the semi-structured interviews. The database file was housed in a file on a password protected

laptop. Moreover, semi-structured interview transcripts were uploaded to ATLAS. ti 8, a qualitative software program, to assist with initial coding of interviews. ATLAS. ti 8 was on the same password protected laptop as the case study database.

Figure 3.1

Chain of Evidence (Yin, 2014, p. 128)



Study Setting

Prisma Health's ED served as the setting for this study and is located in the Upstate of South Carolina. The following emergency rooms are under the ED's umbrella: Greenville Memorial Hospital Adult and Pediatric Emergency Rooms, Greer Memorial Hospital, Hillcrest Memorial Hospital, Laurens County Memorial Hospital, North Greenville Hospital, and Oconee Memorial Hospital. Greenville Memorial Hospital is the flagship hospital for Prisma Health-Upstate and is located in Greenville County, South Carolina. ED sites included in this study were Greenville Memorial, Hillcrest Memorial, and North Greenville Hospitals, all of which are located in Greenville County.

Prisma Health's institutional review board (IRB) approved all research procedures. The ED leadership requested a partial method change from focus groups during staff meetings with ED personnel across job categories to individual interviews because of staff meeting time constraints. The researcher submitted an amendment for the methods change and received Prisma Health's IRB approval on January 24, 2019. Clemson University accepted Prisma Health's final IRB approval. Prior to IRB submission, the researcher had to complete Prisma's Health's student orientation, which included training on various health and safety topics as well as mandatory policies and procedures.

The selection of the Prisma Health's ED is significant since news reports indicate HT activity in the area covered by the hospital (Davis, 2018; Remien, 2018). Greenville County is located in the Upstate region of South Carolina with a population of 514,213 (United States Census Bureau, 2018). The county consists of six cities (Fountain Inn, Greenville, Greer, Mauldin, Simpsonville, and Travelers Rest) and is located between Atlanta, GA and Charlotte, NC, two cities with high incidents of human trafficking (Polaris Project, 2015). There are two major Interstates that run through the county, I-85 and I-26, both of which are recognized as connectors to trafficking destinations, such as Atlanta, GA and Charlotte, NC (Traffickinginsc, n.d.).

Sample

Overall, four sites were included in the data collection process for this study. Convenience sampling assisted with the selection of 13 system-wide policies and procedures and three ED sites for 25 hours of observations of patient data collection at

intake, triage, and medical screening evaluations. Snowball sampling assisted with the selection of 22 ED personnel from different job categories for semi-structured interviews at four ED sites.

Policies and Procedures Selection

Convenience sampling allowed for the selection of system-wide policies and procedures specific patient populations seen during in-take, triage, and medical screening evaluations, patient rights, EMR documentation, and clinical practices. The purpose of the policy and procedure review was to determine whether HT could be incorporated into existing policies to enhance HT identification and response.

Selection criteria guided the review of policies and procedures relevant to the study. The first criterion focused on policies and procedures for vulnerable patient populations like abuse and neglect, sexual assault, and substance and alcohol abuse. The second criterion was geared toward patient rights, such as the language services policy for non-English speaking patients. The third criterion were policies and procedures related to EMS documentation and clinical practices.

ED Site Selection for Observations

Prisma Health has seven hospitals with emergency rooms in the Upstate. Convenience sampling assisted with ED site selection. The criteria consisted of sites from different geographical locations to assess structural readiness for change. For observation purposes, three EDs were selected. Greenville Memorial Hospital (GMH), the largest of the hospital systems is located in downtown Greenville. It is a level I trauma center with dedicated adult and pediatric ERs. The Adult ER (GMH-Adult) has a separate in-take

process for triage. In the pediatric ER (GMH-Pediatric), in-take is conducted during the triage process. The third site was Hillcrest Memorial Hospital (HMH) located in a town outside of Greenville in a suburban community. Hillcrest Memorial Hospital's ER cares for adults and children. At this site, intake also is conducted during the triage process.

Participant Selection

Snowball sampling helped to identify ED healthcare professionals, such as physicians, nurses, social workers, and chaplains, for participation in semi-structured interviews on their perceptions of the ED's readiness to respond to HT. Recently, the ED at GMH established a HT task force that consists of ED and other hospital staff as well as members from community agencies that work with trafficked persons. Members of the ED's Human Trafficking Task Force became the sampling frame to begin selection of participants and to seek recommendations for other ED personnel who might be interested in participating in the study. To participate, the healthcare professionals needed to be employed by the ED for a minimum of one year. Healthcare professionals were sought from difference job categories to elicit a range of perspectives on the ED's current readiness for change.

To begin the semi-structured interview recruiting process, an initial recruitment email was sent to ED staff members on the Human Trafficking Task Force, describing the study and requesting an interview on March 22, 2019. Follow-up emails were sent on April 17, 2019 and April 22, 2019 to those whom did not respond to previous requests. Among the 23 ED staff members on the task force, five consented to an interview. The researcher asked each participant for names and contact information of other ED staff

who might be interested in participating in the study. A recruitment email, along with the study's consent form, was sent to each person recommended for the study. Among ED personnel, 22 participated in the interview process from GMH-Adult ER, GMH-Pediatric ER, HMH, and North Greenville Hospital (NGH).

Measures

To examine the readiness of the ED to respond to HT, data collection consisted of three main sources to answer the proposed research questions. These sources were an assessment of ED system-wide policies and procedures, site observations of standardized patient data collection processes during intake, triage, and the medical screening evaluation, along with semi-structured interviews with ED personnel. Triangulation of data collection methods helped to reduce potential sources of error so as not to compromise the study's validity and reliability (Maxwell, 2005; Rubin & Babbie, 2008). Data collection began on January 25th and ended on May 9th, 2019. Table 3.1 lists the primary variables and definitions investigated for this study.

Table 3.1

Primary Variables and Definitions

Readiness for change	Stages of change: precontemplation, contemplation, preparation, action, and maintenance
Structure	Emergency rooms under the ED's purview
Systems	System-wide policies and procedures, standardized patient data collection processes, and clinical practices

Table 3.1 (continued)

Policies and procedures	System-wide regulations for identifying and treating vulnerable adult and child patient populations as well as policies for intake, triage, and the medical screening evaluation.
Standardized patient data collection	Questions asked of patients during intake, triage, and the medical screening evaluation.
Clinical practice	Questions asked of patients, non-verbals, such as eye contact, as well as formal and informal clinical processes used when concerned about a patient
Trafficked individual	An individual who is exploited for labor and/or commercial sex purposes
Human trafficking indicators	Medical histories, anogenital symptoms, sexual histories, other histories, and tattoos
ED sites	Emergency rooms under the ED's umbrella
Formal processes	Policies and procedures, standardized patient data collection, and clinical standards of care.
Informal processes	Clinician practice knowledge that goes beyond formal processes, building awareness
ED personnel	Range of staff in ED
ED job categories	Chaplin Environmental services Family patient liaison Interpreter Nurses Physicians Social worker
Gender of ED personnel and patient	Female, male, or other
Race of ED personnel and patient	African American, White, other

Table 3.1 (continued)

Ethnicity of ED personnel and patient	Hispanic or non-Hispanic
Patient's language	English, Spanish, or other
Patient age	≤ 17 18-25 26-30 31-35 ≥ 40
ED personnel employment years	≤ 1 1-5 6-10 11-15 16-20 ≥ 20

Systemwide Policy and Procedure Review

A document review of system-wide policies and procedures for vulnerable populations was the first step in the data collection process. System-wide policies and procedures were located on Prisma Health's Plexus intranet in the Manual of Policy Directives, under Administration (010 Series), Patient Services (050 Series) and the Manual of Nursing Staff Policies, Procedures and G. All policy directives were geared toward adult or pediatric patient populations or both. Prisma Health's Human Resources Department directed the researcher on how to find the Manual of Policy Directives on the organization's intranet and which sections of the manual were most likely to house the policies related to this study.

Policies in each section were scanned based on policy title for initial review and then those that appeared related to the study were further examined based on selection criteria

for analysis. In total, 13 policies and procedures were selected. The researcher developed a Policies and Procedures Review form (see Appendix C) in an Excel spreadsheet to consistently document policies and procedures.

Site Observations of Standardized Patient Data Collection

Site observations are an effective method for discovering what people do in particular contexts, including routines and interactional patterns (Darlington & Scott, 2002; Yin, 2009). However, reflexivity is a weakness for observations because the activity may proceed differently while being watched (Yin, 2009). This study used obtrusive observation, meaning that ED personnel knew they were being observed (Rubin & Babbie, 2008). To blend into the hospital environment, the researcher wore scrubs and a visible hospital ID.

Observations at three ED sites provided an understanding of policy implementation, standardized patient data collected as well as informal strategies used by clinicians to gather additional patient information. Areas of site observation included the patient intake, triage, and medical screening evaluation for each site.

The ED Director and Division of Outreach and Community Service Director assisted the researcher with scheduling site observations. Most of the observations were done when either the ED Director or Division of Outreach and Community Service Director were on duty in the ED. When the researcher's ED contacts were not working at a specific site, the Director of Outreach and Community Service Director would email the physician in-charge for the observation timeframe and briefly explain the purpose of the

observation. Observations were conducted at various time points during the week and on weekends to observe different shifts.

Checklists were developed to assess patient data collection efforts throughout the treatment process. A HT indicator checklist and a safety question checklist assisted with the assessment of standardized patient data collection processes. The HT checklist was used for observations during patient intake, triage, and the medical screening evaluation to determine whether questions related to HT were being asked at any point in the patient's treatment process. The safety question checklist was employed in triage because safety questions are at this step in the treatment process. However, if ED personnel asked a safety question during the medical screening evaluation, it would be documented in the comment section on the HT indicator checklist and in field notes.

HT indicator checklist. The HT indicator checklist was used when observing the ED's intake, triage, and medical screening evaluation processes. The checklist contained demographic information on patients in terms of gender, race/ethnicity, age, and whether the patient was accompanied by another person. Names and other identifiers were not documented. Furthermore, the checklist included list of possible human trafficking indictors, generated from current studies on HT (Greenbaum, 2016; Fang, Coverdale, Nguyen, & Gordon, 2018;Varma, Gillespie, McCraken, & Greenbaum, 2015), as detailed in Table 2.1. Dichotomous responses on the checklist included yes (1) and no (0) as to whether ED personnel asked questions related to the indicators. See Appendix D for sample checklist. Patient demographics and HT indicators were documented in field notes and then transferred to an Excel spreadsheet immediately after the observation visit.

Table 3.2

Human Trafficking Indicators

Medical history

- Mental health disorder
- Health visit within a 2-month period
- History of commercial sexual exploitation, commercial sexual exploitation of children (CSEC), and acute sexual assault (ASA)

Anogenital symptoms

- Vaginal discharge
- Genital pain
- Itching
- Abnormal bleeding
- Pelvic pain
- Rectal pain

Sexual history

- How long sexually active
- History of sexually transmitted infection (STI)
- Pregnancy
- Birth control use
- Menstrual problems

Other history

- History of violence with caregivers
- History of fractures, loss of consciousness (LOC), wounds
- History of violence with sex
- History of drug use
- History of multiple drug use
- History of running away
- Child Protective Services (CPS)
- History with polices
- History of suicide

Other

- Tattoos

Safety question checklist. The second checklist focused on safety questions. During the triage process, nurses asked patients 14 and older if they felt safe in their home. For patients under 14, the question was directed to the parent or guardian. For adults, a second safety question pertained to feeling safe in their relationship. Checklist variables were documented in field notes and then immediately transferred to an Excel spreadsheet after the observation visit.

Field notes. Field notes allowed for documentation during site observations and semi-structured interviews. For site observations, the date and treatment process observed were documented in a field notebook used exclusively for this study. The field notebook also provided an avenue for reflection during and after observations. Use of field notes for site observations was less cumbersome than carrying a laptop and less intrusive for patients and ED personnel. Moreover, field notes assisted with data collection during the semi-structured interview process, providing the researcher with data to compare to the transcribed interviews. Field notes were stored in a locked filing cabinet.

Semi-Structured Interviews

In qualitative research, the in-depth interview is a tool used to gather data from participants who are the perceived experts because they are best able to report their lived experiences of an event or phenomenon (Darlington & Scott, 2002). The quality of the interview between the researcher and the participant is essential (Charmaz, 2006; Maxwell, 2005) and helps to target case study topics (Yin, 2009). Darlington and Scott (2002) posit that in-depth interviews are an excellent tool for understanding how participants think or feel about events. In-depth interviews are particularly beneficial for

phenomena that cannot be directly observed (Darlington & Scott, 2002). Interviews also have weaknesses such as response bias and reflexivity (Rubin & Babbie, 2008; Yin, 2009).

Semi-structured interviews with ED personnel assisted in addressing the research questions and provided an opportunity for staff to discuss whether the ED policies and procedures, patient data collection processes, and clinical practices were ready to respond to HT. The one-time interviews were face-to-face at an ED site and arranged through email with the participant. Interviews ranged in length from 20 minutes to 42 minutes. Prior to the start of each interview, the researcher reviewed the Informed Consent Form, stressing voluntary participation, the potential risk and benefits, the protection of confidentiality, and asking permission to audio record the interview. The researcher asked for permission to audio record the interviews and then had the participant initial his or her response in the audio recording section of the Informed Consent document. Next, the participant and the researcher signed and dated the Informed Consent form.

Interviews started with participant demographic information and then moved into questions structured to solicit their perceptions of the ED's current readiness to respond to HT. (See Appendix F for the interview protocol.) Each participant was asked the same questions and in the same order to ensure consistency.

After each interview, the researcher uploaded the audio recording to a Dropbox folder and shared the audio file with a transcriber. For recording purposes, the researcher used the Audio Memos app on an iPhone. The transcriber then emailed the transcript back to the researcher. Upon receipt of the interview transcription, the researcher

compared the transcript with the original recording and field notes to ensure accuracy and then uploaded the transcript to ATLAS. ti 8 for analysis. After completion of the accuracy check, the interviews were deleted from the iPhone.

Prior to receiving any audio recordings, the transcriber signed a Transcriber's Confidentiality Agreement (see Appendix G). Moreover, the researcher entered participant demographic data and responses to each question into an Excel spreadsheet for descriptive analysis, specifically frequencies and percentages.

Data Analysis

Content and thematic analysis were conducted, along with frequencies and percentages to determine the ED's current readiness. Content analysis aided in analyzing the policies and procedures and checklists used during the site observations of patient data collection processses to describe the data. Thematic analysis assisted with the analysis of the semi-structured interviews to report patterns within the data (Vaismoradi, Turunen, & Bondas, 2013). Both forms of analysis are commonly used in healthcare research. Futhermore, descriptive statistics that included frequenies and percentages assisted in describing site observation data as well as participant responses.

Content Analysis

When using content analysis, the goal is to become immersed in the data to get a sense of the whole (Vaismoradi, Turunen, & Bondas, 2013). For the purpose of this study, content analysis helped to describe system-wide policies and procedures that might be suitable for incorporating HT into the existing data system. Each policy, along with its

procedures, were reviewed and documented in the Excel Policies and Procedures Review form. Recommendations for HT inclusion were noted on the form and specified where and how to incorporate HT into selected policies.

The researcher performed content analysis for the site observations of patient data collection to identify patterns in the data and across sites. Demographic and checklist data were entered into Excel spreadsheets with codes for analysis. Codes for the Human Trafficking Indictor Checklist and the Safety Question Checklist included 1 (yes), 2 (no), and 0 (not asked or addressed). A numerical summary, using frequencies and percentages, allowed for the interpretation of data and to determine the change of stage for patient data collection to respond to HT as well as the change of stage for each observation site.

Thematic Analysis

Data analysis for the semi-structured interviews was based on thematic medthodololgy for qualitiatve research to build a conceptual framework of the ED's current readiness (Miles & Huberman, 1994). The use of thematic analysis allowed the researcher to become familiar with the data by transcribing data, reading the data, and then noting initial ideas. The thematic analysis process is not linear, rather it is recursive process, requiring the researcher to apply flexibly to understand the data (Braun & Clarke, 2006). The thematic analysis process adopted for this study was Braun and Clark's (2006), six-phase framework. The six phases include: 1) becoming familiar with the data. 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining themes, and 6) writing-up themes.

For this study, interviews were audio recorded and the researcher took field notes to begin the analysis process. An Excel spreadsheet assisted in tracking participants' demographic information and interview responses. After each interview, participant data was entered into the Excel spreadsheet, along with memos of the interview. Then audio recordings were sent to an independent transcriptionist.

Upon receipt of the transcribed interviews, the researcher reviewed the transcriptions with the audio recording to ensure accuracy. Then the transcription was uploaded into Atlas. ti 8. Next, each interview transcription was reviewed line-by-line to establish initial codes and compared to data in the field notebook as well as the Excel interview spreadsheet. After the initial coding process, the researcher created an Atlas. ti 8 report that consisted of 505 initial codes. Then the researcher used an iterative process of rereading data to refine codes and organize them into categories. This step resulted in 44 supporting codes that were collated into 11 emerging themes. Table 4.13 shows the breakdown of emerging themes, along with response percentages. A final review of emerging themes allowed for the gathering of data into five emergent themes, as shown in Appendix A**.** The five emergent themes were named and defined. The generation of a thematic map helped to determine the relationship between the themes and story they told about the ED's readiness to respond to HT. Finally, a peer review of the themes by a colleague with limited HT knowledge, validated the five emergent themes.

Validity and Reliability

This section provides an overview of steps used to ensure the study's validity and reliability. Since qualitative research provides a significant contribution to the healthcare field, it is critical to assess for quality and robustness (Leung, 2015). The implementation of fundamental concepts of validity and reliability are essential for the trustworthiness of qualitative research (Leung, 2015). Validity indicates that a measure accurately reflects the concept it is intended to measure (Rubin & Babbie, 2008), whereas reliability refers to the consistency of research procedures and results (Creswell, 2014). Ultimately the goal of reliability is to reduce errors and potential biases in a study.

Validity

Yin (2014) argued that one criterion for judging the quality of a research design was construct validity. For this study, the researcher developed operational variables and definitions to enhance consistency and to reduce subjectivity (see Table 3.1). In this case study design, construct validity consisted of using multiple sources of evidence, establishing a chain of evidence, as depicted in Figure 3.1, and having key informants, or in this situation my committee, review the draft case study report (Amerson, 2011; Yin, 2014).

Several validity strategies existed to assess the accuracy of findings in this study. First, the research engaged in extended fieldwork. Data collection began on January 31, 2019 and ended on May 9, 2019. Extended fieldwork allowed for context rich data,

consisting of various observation times and ED personnel from three ED sites and in-depth interviews with ED personnel from four ED sites.

Triangulation was part of the extended fieldwork process. This study included multiple data sources and methods, including a review of system-wide policies and procedures and observations of patient data collection at three different sites during the intake, triage, and medical screening evaluation processes. Each site received a minimum of two observations at different time points for a total of 25 observation hours. Moreover, the semi-structured interviews with 22 ED personnel from eight job categories helped to provide a broad understanding of the ED's current readiness by staff in clinical and non-clinical positions.

Each step in the data collection process provided evidence of the ED's readiness to respond to HT. For example, during the site observations, the researcher assessed policy implementation, patient data collected, and clinical practices. These three systems also were addressed in semi-structured interviews with participants. To ensure findings were internally coherent, the researcher linked data from each system to the adapted TTM Stage of Change Model to determine readiness.

Another important aspect of qualitative research to ensure validity is reflectivity. According to Mortari (2015), the researcher has an ethical task to make the process valid through transparency and accountability. One step the researcher took to eliminate biased assumptions was to ask follow up questions during interviews to ensure that the point made by the participant was clear. Another step was to enter data into excel spreadsheets

after each data collection point to check for accuracy and reflect on the process. The researcher also reflected on findings when writing up the report to guard against personal influence and experiences.

When necessary, the researcher sought out assistance from committee members to validate finings. This step ensured that results resonated with somebody other than the researcher (Creswell, 2009). A peer reviewer also assessed the thematic analysis process and themes to ensure valid results. The reviewer was not part of the study and did not have knowledge of HT. Having another person to debrief with allowed the researcher to explain the analysis process and to clarify how findings were formulated.

Finally, external validity focuses on how much the study's findings can be generalized to other settings. This study presented a clear description of the characteristics of the sample in terms of participants, ED sties, and processes, allowing for comparison with other EDs and healthcare settings, such as urgent care centers. The thick description of the study's results helped to show transferability to other healthcare settings.

Reliability

Equally important to a study's validity is its reliability. Reliability focuses on the quality of the measurement method that allows for collection of the same data across sites (Rubin & Babbie, 2008), helping to reduce errors and biases in the study (Yin, 2009). The researcher used various reliability strategies throughout the data collection process and was the only person collecting data. For example, data was collected across ED sites,

at different time points, and with a range of personnel. Prior to data collection, the researcher developed instruments to consistently assess system-wide policies and procedures and site observations of patient data collection processes. In addition to data collection instruments, the research took field notes and created Excel spreadsheets for data input and content and descriptive statistical analysis. Codebooks provided clear code definitions for the intake, triage, and medical screening evaluation processes.

Specific to the interviews, the use of a semi-structured interview guide helped to ensure reliability. The interview guide was tailored to elicit the same information from a range of ED personnel to assess similarities and differences in participants' perspectives. Interviews were audio-recorded and then transcribed. The researcher reviewed each transcribed interview against the audio version as well as field notes to ensure accuracy. Again, the researcher took field notes, created an Excel spreadsheet for interview input and descriptive statistical analysis, along with a codebook with defined codes. The Excel spreadsheet and interview transcripts were uploaded into ATLAS. ti 8 for thematic analysis. Careful consideration of the aforementioned steps assisted with validity and reliability for this study.

Methodological Limitations

Although data collection extended over a four-month period, the site observations that included specific healthcare personnel and the semi-structured interviews resulted in a one-point in time assessment. Data collection consisted of two observations for each of the three sites, one for each site's intake/triage process and a second observation of the

medical screening evaluations. The researcher did not have the opportunity to observe patient data collection processes or clinical practices for vulnerable patients, meaning patients seeking medical care for sexual assault, domestic violence, or child abuse and neglect. More in-depth patient data collection is most likely required when ED personnel have suspected or confirmed knowledge of vulnerable patients.

The ED personnel from different job categories interviewed for this study provided insight on the current readiness of the ED to respond to HT. The ED personnel who agreed to participate might have more of an interest in and awareness of HT than staff who declined or were unresponsive to interview requests. The sampling methodology, therefore, was not unbiased. Despite the methodological limitations, site observations and participants' perceptions reveled areas for systematic improvement within the ED, as discussed in the next chapter.

CHAPTER FOUR

RESULTS

The ED is a complex department with its various sites and systems. To thoroughly assess the ED's readiness to respond to HT, data collection began with the ED's system-wide policies and procedures. The second step was site observations to assess patient data collection processes, while the third step in the data collection process was the semi-structured interviews with a range of ED personnel. In this section, a discussion of the findings uses a similar sequence, starting with results from the system-wide policies and procedures review. The medical treatment processes section highlights findings from patient in-take, triage, and the medical screening evaluation. Next is the perceptions of the ED's current readiness based on findings from participants' interviews. This section provides a detailed description of the five emergent themes. Each theme is supported by emergent themes and participants' quotes to illustrate the ED's current readiness to respond to HT. Then a discussion follows on the thematic map, showing how the themes link together and their level of readiness. The chapter concludes with a summary of the study's findings.

System-Wide Policies and Procedures

Policies and procedures are the guiding force for healthcare settings. The ED's policies and procedures are in Plexus on Prisma Health's intranet and clearly state if the policy is system wide as well as the intended patient population, meaning adult or pediatric.

Currently, Prisma Health does not have a policy or procedures for HT; therefore, 13 system-wide policies and procedures for Prisma Health's ED were assessed for the intersection of HT. Among the 13 policies and procedures, eight appeared well-suited for the inclusion of HT. Categorization of eight policies by policy name and number, along with patient population is described in Table 4.1.

Table 4.1

Prisma Health System-Wide Policies Suited for HT Inclusion (n = 8)

Policy Name	Policy Number	Patient Population
Documentation of Acute Nursing Care	N-009	Adult and Pediatric
Language Services	S-050-49	Adult and Pediatric
Recognition and Reporting of Abuse and Neglect of Children And Vulnerable Adults	S-050-55	Adult and Pediatric
Patient Monitoring During Transfer Within a Facility	S-050-096	Adult and Pediatric
Patient Observation	S-050-100	Adult and Pediatric
Abuse, Neglect and Reasonable Suspicion of a Crime on a Prisma Health Property	S-050-102	Adult and Pediatric
Emergency Department Triage Sexual Assault Examination, Child and Adolescent	S-050-127 S-050-224	Adult and Pediatric Pediatric
Sexual Assault Examination	S-050-225	Adult

The policies and procedures listed in Table 4.1 provide an avenue for the inclusion of human trafficking. Results related to how and where to intersect human trafficking into each of the nine policies is discussed in Chapter 5 in the recommendation section.

Results showed that system-wide policies and procedures that impact the ED are at the precontemplation level for the TTM's Stage of Change Model, meaning that the policies and procedures do not recognize HT, and therefore, are not ready to respond to HT. A total of 13 policies and procedures were reviewed to determine readiness for change. Of the 13 policies and procedures, nine would allow for revisions that would include human trafficking guidance. The remaining 4 policies interface with human trafficking and would prove beneficial in identifying trafficked individuals as well as providing more effective treatment options. Since policies and procedures provide a framework for patient treatment, thereby guiding clinical practice, revisions to include human trafficking should be a priority for the ED to improve its response efforts. For an effective human trafficking response, the goal for the ED should be to systematically move this structural component from the precontemplation stage of change to the maintenance stage. The maintenance stage would allow the ED to evaluate the revised policies and procedures to ensure the procedural guidance effectively addresses aspects of HT identification and treatment. Policies and procedures, however, are the first step to improving the ED's response. The ED's medical treatment processes are another area that require the incorporation of HT.

Medical Treatment Processes

The second data collection step consisted of conducting observations in three of the ED's emergency rooms to assess policy and procedures implementation, standardized patient data collection processes, and clinical practices. Observations were conducted during in-take, triage, and the medical evaluation for a total of 25 hours. Data collection instruments included the "Safety Question Checklist" in Appendix E that are part of the screening process for abuse and neglect, as indicated in the "Documentation of Acute Nursing Care, "policy N-009. Another data collection tool was the "Human Trafficking Indicator Checklist" (Appendix D), used to determine whether the indicators were part of the standardized patient information process. Finally, field notes were taken during observations to further document the processes and to record possible recommendations for improvement.

What is the readiness for change within the ED's systems to respond to HT that include policies and procedures, patient data collection, and clinical practices? Addressing research question 1, findings demonstrated that the standardized patient data collection processes were at the precontemplation stage of change, indicating low levels of readiness overall to respond to HT. Current patient data collection question do not recognize HT and are unlikely to help ED personnel identify trafficked individuals.

Results are based on 79 patient encounters from January 31, 2019 through March 6, 2019. Patient demographics are shown is Table 4.2 for the three facilities. To ensure confidentially, patients' names were not documented or the presenting medical issue that required emergency care.

Table 4.2

Patient Demographics (*n* = 79)

Patient Characteristics	*n* (%)
Gender	
Male	32 (40.5)
Female	47 (59.4)
Accompanied by another person	
Yes	58 (73.4)
No	21 (26.5)
Age	
>17 years	33 (41.7)
18 – 30 years	9 (11.3)
31 – 40 years	14 (17.7)
41 – 50 years	9 (11.3)
51 – 60 years	1 (1.2)
61 – 70 years	1 (1.2)
<70 years	4 (5.6)
Undetermined	8 (10.1)
Race/Ethnicity	
African American	13 (16.4)
White	44 (55.7)
Mixed Race	3 (3.8)
Hispanic	11 (13.9)
Undetermined	8 (10.1)
Language	
English	72 (91.1)
Spanish	6 (7.5)
Other	__
Undetermined	1 (1.2)

Note: A __ refers to undetermined results for patients at in-take for the Adult emergency room.

As the results indicate in Table 4.2, 42% of patients were 17 years or younger and 58% were adults. The majority of patients and parents/guardians spoke English (91%),

while 8% spoke Spanish only. An interpreter must be called for a non-English speaking patient during the medical screening evaluation, as per the Language Services policy (S-050-49). Healthcare professionals followed this policy for the observed non-English speaking patients.

In-take Process

When a patient enters the emergency room, the first step for medical care is patient in-take. During this process, the patient provides basic information, such as name, address, date of birth, and reason for the visit. Among the three Prisma emergency room sites observed, Greenville Memorial Hospital is the only one that conducts the in-take process separate from triage.

In accordance with the "Documentation of Acute Nursing Care" policy (N-009), a registered nurse at in-take asked patients basic demographic questions, the chief complaint, and recent travel history. Of the eight patients observed at adult in-take, six were accompanied by another person. Each patient received a number identification for privacy and asked to sit in the waiting room. The nursed called out the number rather than the patient's name when it was time to proceed to triage. This was the only observed site that provided patients with a number identification for privacy.

Observations of the adult intake did not allow for a patient's age and race/ethnicity to be determined. Language could not be determined for one elderly patient because the person accompanying her responded to the intake questions. The nurse did not attempt to direct questions to the patient.

The other two sites combined in-take and triage processes. One of the sites was the Pediatric Emergency Room (PEDS). Patients register at the front desk with demographic information and then take a seat in the PEDS waiting room. The triage nurse called the patient's name and then conducted the in-take and triage process. The third observation site was for adults and children. When a patient walked into the emergency room, they proceeded to the front desk where the patient or parent/guardian filled out a short form that included the patient's name, date of birth, and address and gave it to the front desk staff person who then handed it to the triage nurse. The patient was asked to take a seat in the waiting room. When the registered nurse was ready, the patient's name was called for in-take and triage.

Triage Process

The next step to medical treatment is the triage process that consists of systemwide policies and procedures, standardized patient data collection, and clinical practices. Of the 79 observed patients, 47 were seen in triage. The chief complaint assisted the nurse in determining a patient's placement within the ED through the emergency severity index level (ESL), as per the "Emergency Department Triage" policy (S-050-127). Along with the chief complaint, the nurse evaluated a patient's condition visually and through standardized assessment and screening questions in the EMR. Part of the admission assessment documentation is screening for abuse and/or neglect, as stated in the "Documentation of Acute Nursing" policy (N-009). One of the required safety questions (SQ1) asked of adults and parents/guardians of children was "Do you feel safe in your

home?" A second required safety question (SQ2) for adults only was "Do you feel safe in your relationship?"

Safety question 1. During the triage observation phase of the study, nurses asked SQ1 for 74% of all observed adult patients and parents/guardians. Table 4.3 provides the triage patient characteristics for the three sites. Among the 47 triage patients, 42.5% were observed in the GMH-Pediatric ER, 25.5% in GMH-Adult ER, and 32% at HMH.

Table 4.3

Triage Patient Demographics (*n* = 47)

Patient Characteristics	Adult n (%)	Pediatric n (%)
Gender		
Male	8 (17.0)	14 (29.8)
Female	17(36.2)	8 (17.0)
Accompanied by another person	12 (25.5)	22(46.8)
Race/Ethnicity		
African American	8 (32.0%)	4 (18.2)
White	15 (60.0%)	10 (45.5)
Mixed Race	1 (4.0%)	2 (9.1%)
Hispanic	1 (4.0%)	6 (27.3)
Language		
English	25 (100%)	18 (81.8)
Spanish		4 (18.2)

Table 4.4 details outcomes for SQ1. Among the 35 patients and parents/guardians asked SQ1, all responded that they felt safe in their homes. Nurses were least likely to ask SQ1 in the pediatric ER. At HMH, one nurse did not ask SQ1 but answered the question

for the patient, saying “Of course you feel safe in your home.” The patient, an elderly woman, looked at the nurse but did not respond. The same nurse said to another patient, “We’re going to put in that you’re not suicidal and feel safe in your home and in your relationship.” Again, the patient, a male in his early 20s, looked at the nurse but did not respond. The nurse’s actions were not common practice observed in triage.

Since nurses are entering patient data into the EMR when asking screening questions, they did not consistently look at the patient for a response to safety questions and might have missed non-verbal cues by a patient as well as an opportunity to ask follow-up questions. Of the 35 patients and parents/guardians asked SQ1, nurses made eye contact with 86%, and 80% of patients and parent/guardians made eye contact with the nurse. SQ1 was asked of female and male patients.

Table 4.4

Safety Question 1 - Do You Feel Safe in Your Home? (*n* = 47)

SQ1 Observed Reactions	Adult Patients *n* = 25 (53.2%)	Pediatric Patients *n* = 22 (46.8%)
SQ1 Asked for Adult Patients	22 (88.0%)	
Nurse Eye Contact with Adult Patient	17 (77.2%)	
Patient Eye Contact with Nurse	17 (77.2%)	
Patient Verbal Response	17 (77.2)	
Parent Felt Safe	22 (100%)	

Table 4.4 (continued)

SQ 1 Asked for Pediatric Patients	13 (59.0%)
Nurse Eye Contact with Parent/Guardian	13 (100%)
Parent/Guardian Eye Contact	11 (84.6%)
Parent/Guardian Verbal Response	13 (100%)
Parent/Guardian Felt Safe	13 (100%)

Safety question 2. Findings showed that 92% of adult patients were asked SQ2, as shown in Table 4.5. Patients not asked SQ2 included 4% of male patients and 2% of female patients. Nurses made eye contact with 73.9% of patients and the same percentage of patients made eye contact with nurses. As Table 7.1 suggests, all the patients who were asked SQ2 either provided a verbal response (70%) or nodded in the affirmative (30%) that they felt safe in their relationship.

Table 4.5

Safety Question 2 – Do You Feel Safe in Your Relationship? (*n* = 25)

SQ2 Observed Reactions	*n* (%)
SQ2 asked for adult patients	23 (92.0%)
Nurse made eye contact with patient	17 (73.9%)
Patient made eye contact with nurse	17 (73.9%)

Table 4.5 continued

Patient gave verbal response	16 (69.6%)
Parent felt safe	23 (100%)

Additional screening questions. Among the six observed nurses in triage, two asked additional screening questions to assess patient safety, such as alcohol and substance abuse as well as suicide risk. In the "Documentation of Acute Nursing" policy (N-009), indicates that psychosocial needs should be assessed, including alcohol and/or substance abuse. Suicide risk screening, however, is recommended if an indication is present.

One observed nurse in triage at GMH Adult ER consistently asked nine of the 10 patients additional screening questions. The patient who was not asked had a medical emergency and was transported to another area of the ER. The nurses screened for drug and alcohol use. To screen for suicide risk, the nurse asked: 1) Do you wish you were dead? and 2) Do you wish you would never wake up? Of the nine patients asked additional screening questions, one patient, a female over the age of 60, responded yes to both questions.

Among pediatric patients two were asked suicide risk questions. In GMH's Pediatric ER, one nurse asked the two aforementioned suicide screening questions to a 14-year-old male patient who presented with suicidal ideations. The patient responded no to both questions. Then the nurse asked if he was suicidal. Again, he responded no. A second

nurse at the same facility asked a 17-year-old male patient who presented with suicidal ideations if he wanted to harm himself or others. He responded yes to both questions.

SQ Variation by ED Site

Research question 3 asked, how does system readiness for change to respond to HT vary across ED sites? Results indicated that it was standard protocol to ask safety questions at each observed site, yet Tables 4.4 and 4.5 showed that ED personnel are inconsistent in gathering SQ information. Results also demonstrated inconsistencies across ED sites, as displayed in Table 4.6.

Table 4.6

Safety Questions Asked by ED Site

Safety Question	GMH-A *n* (%)	GMH-P *n* (%)	HMH *n* (%)
SQ1 Do you feel safe in your home?	8 (66.6%)	10 (50.0%)	11 (73.3%)
SQ2 Do you feel safe in your relationship?	8 (66.6%)	__	9 (60.0%)

Note: The __ means the question was not asked to pediatric patients.

Human trafficking indicators. Along with safety questions, human trafficking indicators were tracked to determine if they were part of the standardized patient data collection process in triage. Table 4.7 lists the human trafficking indicators and whether a specific indicator was asked for adult and pediatric patients. Adult patients were more likely to be asked questions associated with these indicators. The history of multiple drug

use, including alcohol use, was the most asked indictor. However, one nurse at GMH-Adult ER asked questions about drug and alcohol use to 36% of the patients. Of the 10 patients observed with this nurse, eight were female and two were male. One man who was seen by the nurse had a medical emergency and was not asked screening questions. Questions related to indicators in three other categories were asked but only of female patients at GMH-Adult ER. For instance, 20% of adult patients were asked questions related to indicators under the sexual history category. These patients presented with an issue related to the category. The third most common issues asked of 12% of patients were associated with anogenital symptoms. Under the medical history category, 8% of patients were asked about mental health because mental health issues were noted in their EMR from previous visits. Finally, results showed that patient data collection did not include any questions related to patients' tattoos.

As for the pediatric patients, 18% were asked about mental health. Each of these patients presented with a mental health issue and were seen at GMH-Pediatric ER. Among these four patients, three were White males and ranged in age from 8 to 17. The fourth patient was a 16-year-old Hispanic female whose mother spoke limited English. The nurse stated that an interpreter would be available during the medical screening exam. Observed patient data collection did not include any other possible human trafficking indictors.

Table 4.7

Human Trafficking Indicators Asked in Triage, n = 47

Indictor	Asked AP *n* = 25	Asked PP *n* = 22
Medical History		
Mental health disorder	2 (8.0%)	4 (18.2%)
Health visit within 2-month Period	—	—
History of CSEC, ASA	—	—
Anogenital Symptoms		
Vaginal discharge	1 (4.0%)	—
Genital pain	—	—
Itching	—	—
Abdominal bleeding	—	—
Pelvic pain	2 (8.0%)	—
Rectal pain	—	—
Sexual History		
How long sexually active	—	—
History of STIs	—	—
Pregnancy	2 (8.0%)	—
Birth control use	2 (8.0%)	—
Menstrual problem	1 (4.0%)	—
Histories		
History of violence with caregivers	—	—
History of fractures, LOC, wounds	—	—
History of violence with sex	—	—
History of drug use	—	—
History of multiple drug use (alcohol)	9 (36%)	—
History of running away	—	—
History with CPS	—	—
History with police	—	—
History of suicide	—	—

Table 4.7 (continued)

Tattoos	__	__

Note. AP refers to adult patients and PP to pediatric patients. Under medical history, CSEC is for commercial sexual exploitation of children and ASA is for acute sexual assault. The __ means the HT indicator was not addressed.

ED Site Variation during Triage Process

Findings proved that ED personnel do ask questions related to HT indicators. ED personnel, gathered additional information based on the presenting medical issue and when a patient volunteered information, as shown in Table 4.7**.**

Moreover, HT indicator results varied by ED sites, as demonstrated in Table 4.8. ED personnel at the GMH-Adult ER were more likely to ask a range of questions related to the HT indicators during the triage process, based on the presenting medical issues. The most frequent questions at GMH-Adult ER pertained to history of multiple drug use, which included alcohol. The ED personnel at GMH-Pediatric ER addressed the mental health disorder indicator for four patients, while HMH personnel did not ask questions related to HT indicators.

Table 4.8

Human Trafficking Indicators Asked during Triage per Site

Indictor	GMH-A *n* (%)	GMH-P *n* (%)	HMH *n* (%)
Medical History			
Mental health disorder	2 (16.6%)	4 (20.0%)	__
Health visit within 2-month	__	__	__
Period	__	__	__
History of CSEC, ASA	__	__	__

Table 4.8 (continued)

Anogenital Symptoms			
Vaginal discharge	1 (08.3%)	__	__
Genital pain	__	__	
Itching	__	__	__
Abdominal bleeding	__	__	__
Pelvic pain	2 (16.6%)	__	__
Rectal pain	__	__	__
Sexual History			
How long sexually active	__	__	__
History of STIs	__	__	__
Pregnancy	2 (16.6%)	__	__
Birth control use	__	__	__
Menstrual problem	1 (08.3%)	__	__
Histories			
History of violence with caregivers	__	__	__
History of fractures, LOC, wounds	__	__	__
History of violence with sex	__	__	__
History of drug use	__	__	
History of multiple drug use (alcohol)	9 (75.0%)	__	__
History of running away	__	__	__
History with CPS	__	__	__
History with police	__	__	__
History of suicide	__	__	__
Tattoos	__	__	__

Note. Under medical history, CSEC is for commercial sexual exploitation of children and ASA is for acute sexual assault.

Medical Screening Exam

The final observed patient data collection process was the medical screening exam. During this data collection phase, 24 patients were observed along with six physicians at three sites. Table 4.9 highlights the characteristics of observed patients. The medical screening exam observation consisted of seven patients at GMH-Adult ER and 10

patients at GMH-Pediatric ER. At HMH's ER, six adult patients and one child were observed.

Table 4.9

Medical Screening Evaluation Patients, n = 24

Characteristic	AP *n* = 13	PP *n* = 11
Gender		
Male	6 (46.2%)	2 (18.2%)
Female	7 (53.8%)	9 (81.8%)
Accompanied by another person	9 (69.2%)	11 (100%)
Race/Ethnicity		
African American	1 (7.7%)	__
White	12 (92.3%)	5 (45.5%)
Mixed Race	__	1 (9.1%)
Hispanic	__	5 (45.5%)
Language		
English	13 (100%)	9 (81.8%)
Spanish	__	2 (18.2%)

Note: The __ means no data representing the category.

Language services. Of the 24 patients observed during the medical screening exam, two parents required a Spanish language interpreter at GMH-Pediatric ER. One physician had both non-English speaking parents and followed the "Language Services" policy (S-050-49) by calling the in-house Language Services Department for an interpreter. Each parent had an in-person interpreter for the exam with their children.

Human trafficking indicators. Questions related to human trafficking indicators were less likely to be asked during the medical screening exam, as indicated in Table 4.9.

However, questions related to indicators in three categories were discussed between physicians and patients. For example, two adult patients presented with mental health issues at GMH-Adult ER. The physician asked a White, female patient about psychotropic medication previously documented in the patient's EMR. Then the physician asked if the patient had thoughts of harming herself or others. Next, the physician called for a social work consultant. The second patient, a White male, who presented with a mental health issue was asked by the physician if he was ever admitted to a psychiatric hospital. The physician also asked about suicidal and homicidal thoughts as well as history of drug and alcohol use. The physician then called for a social work consult.

During a medical screening exam observation at HMH's ER, a White, female patient presented with a medical issue but revealed a mental health history when asked about current medications. No other indicators were asked of the patient.

At HMH's ER, a physician asked a patient and then a parent of a two-year old questions related to the indicators. An adult, White, male patient presented with a medical issue and was asked about drugs and alcohol use. Another patient was a two-year old White female who presented with genital pain. The physician did not address any other indicators with the adult patient or the child's parent.

Table 4.10

Human Trafficking Indictors Asked in Medical Screening Evaluation, n = 24

Indictor	Asked AP *n* (%)	Asked PP *n* (%)
Medical History		
Mental health disorder	3 (23.1%)	—
Health visit within 2-month Period	—	—
History of CSEC, ASA	—	—
Anogenital Symptoms		
Vaginal discharge	—	—
Genital pain	—	1 (9.1%)
Itching	—	—
Abdominal bleeding	—	—
Pelvic pain	—	—
Rectal pain	—	—
Sexual History		
How long sexually active	—	—
History of STIs	—	—
Pregnancy	—	—
Birth control use	—	—
Menstrual problem	—	—
Histories		
History of violence with caregivers	—	—
History of fractures, LOC, wounds	—	—
History of violence with sex	—	—
History of drug use	—	—
History of multiple drug use (alcohol)	2 (15.4%)	—
History of running away	—	—
History with CPS	—	—
History with police	—	—
History of suicide	—	—

Table 4.10 (continued)

Tattoos	__	__

Note. AP refers to adult patients and PP to pediatric patients. Under medical history, CSEC is for commercial sexual exploitation of children and ASA is for acute sexual assault. The __ means no data for the represented category.

ED Site Variation during Medical Screening Evaluation

Site variations with HT indicators were present during observations of the medical screening evaluation. Table 4.11 highlights the differences between ED sites. Similar to the triage process, ED personnel in GMH-Adult ER were more likely to ask questions related to HT indicators. Among the 12 patients observed during the medical screening evaluation at GMH-Adult ER, 29% were asked about mental health disorders and history of drug use. AT HMH ER, ED personnel asked one patient about a mental health disorder and another patient about genital pain. During the medical screening evaluation, ED personnel did not address any of the HT indicators for patients at GMH-Pediatric ER.

Table 4.11

Human Trafficking Indicators Asked during Medical Screening Evaluation per Site

Indicator	GMH-A *n* (%)	GMH-P *n* (%)	HMH *n* (%)
Medical History			
Mental health disorder	2 (28.5%)	__	1 (14.2%)
Health visit within 2-month	__	__	__
Period	__	__	__
History of CSEC, ASA	__	__	__

Table 4.11 (continued)

Anogenital Symptoms			
Vaginal discharge	__	__	__
Genital pain	__	__	1 (14.2%)
Itching	__	__	__
Abdominal bleeding	__	__	__
Pelvic pain	__	__	__
Rectal pain	__	__	__
Sexual History			
How long sexually active	__	__	__
History of STIs	__	__	__
Pregnancy	__	__	__
Birth control use	__	__	__
Menstrual problem	__	__	__
Histories			
History of violence with caregivers	__	__	__
History of fractures, LOC, wounds	__	__	__
History of violence with sex	__	__	__
History of drug use	2 (28.5%)	__	__
History of multiple drug use (alcohol)	1 (14.2%)	__	__
History of running away	__	__	__
History with CPS	__	__	__
History with police	__	__	__
History of suicide	__	__	__
Tattoos	__	__	__

Note. Under medical history, CSEC is for commercial sexual exploitation of children and ASA is for acute sexual assault.

Perceptions of ED's Current Readiness

The final data collection phase consisted of semi-structured interviews with 22 ED healthcare professionals. The interviews allowed for an in-depth assessment of the ED's current readiness to respond to HT based on the perceptions of healthcare professionals working within its system. These healthcare professionals worked at Greenville

Memorial Hospital (GMH) Adult ER, GMH Pediatric ER, Hillcrest Memorial Hospital (HMH) ER, and North Greenville Hospital (NGH) ER. Table 4.12 provides participant demographic characteristics across the ED. Among the participants, 23% were members of the department's Human Trafficking Task Force and consisted of 60% clinical staff and 40% non-clinical. In total, 77% of the ED personnel interviewed were clinical staff.

Table 4.12

Participant Characteristics Across Four ED Sites

Characteristic	*n* (%)
Gender	
Female	15 (68.2%)
Male	7 (31.8%)
Other	—
Race/Ethnicity	
Asian	—
Black	2 (9.1%)
Hispanic/Latino	2 (9.1%)
White	18 (81.8%)
Education	
Some college	1 (4.5%)
Associate degree	4 (18.2%)
Bachelor degree	8 (36.4%)
Master degree	5 (22.7%)
PhD	1 (4.5%)
Medical degree	3 (13.6%)
Job category	
Chaplain	2 (9.1%)
Environmental services	1 (4.5%)
Family patient liaison	1 (4.5%)
Interpreter	1 (4.5%)
Physician	3 (13.6%)
Registered nurse	11 (50%)
Social worker	2 (9.1%)
Unit secretary	1 (4.5%)

Table 4.12 (continued)

Years in position	
1 – 5	11 (50%)
6 – 10	8 (36.4%)
11 – 15	__
16 – 20	2 (9.1%)
21—25	1 (4.5%)
Professional license	
Board certified chaplain	1 (4.5%)
Board certified emergency medicine	3 (13.6%)
Certification commission for healthcare interpreters	1 (4.5%)
Licensed master social worker	2 (9.1%)
Registered nurse	11 (50%)
Human trafficking training	
Through hospital system	5 (22.7%)
Through continuing education for license	3 (13.6%)
Through community organization	3 (13.6%)

Note: The __ means no data for the represented category.

Participants consisted of healthcare professionals in various ED job categories with 1 year to 21 years in their current position. Of the 22 participants, 50% have had some training on HT. Participants who received training indicated that the content was general knowledge about HT and mostly focused on sex trafficking.

Prisma Health had a computer-based training on HT that two (18%) of the 11 participants took within the past two years and one participant attended a training at GMH. The remaining two participants with HT training through the hospital stated that they received information at a staff meeting.

Participants represented eight different job categories within the ED, allowing for a range of perceptions on the ED's stage of readiness to respond to HT. Registered nurses

made up the majority of participants (50%), followed by physicians (13.6%), as described in Table 4.12. The interview protocol allowed participants to describe their unique backgrounds, knowledge of HT as well as their perceptions on how the ED's systems might help or hinder the identification of trafficked individuals. Through the iterative process of data coding across participant's interview responses, five dominant themes emerged, resulting in a rich understanding of the ED's systems and interpreted through the TTM stage of change framework.

Table 4.13 provides a percentage breakdown of 11 supporting codes from the interview data. Through further analysis, these codes were condensed to five overarching themes that depicted readiness within the ED's structure and systems. Appendix A highlights the emergent themes, supporting codes and interview quotes and connection to ED systems. The following section describe the five emergent themes on the ED's current readiness to respond to HT.

Table 4.13

Emerging Themes Based on Perceptions of ED Readiness

Believe trafficked persons are seeking medical care	100
Suspected HT	
ED personnel who suspected child trafficking	13.6
ED personnel who suspected adult trafficking	9.0
Have knowledge to identify trafficked persons	54.5
Ways of working within organization	
Across vulnerable populations	40.9
Siloed	59

Table 4.13 (continued)

Patient warning signs	
Accompanying person answering questions	36.3
Changing story	4.5
Defensive/protective body language	18.1
Eye contact avoidance	22.7
Multiple ED visits	13.6
Patient exhibits nervous behavior	18.1
Patient history	9.0
Patient unable to answer basic questions about self	18.1
Presenting problem	9.0
Sense something is wrong	40.9
STDs	9.0
N/A	4.5
Interpretation Services	
Use in-person services	72.7
Use iPad to connect to services	3.6
Use telephone to connect to services	22.7
Handling of patient withholding information	
Asking open ended/direct questions	59.0
Being emotionally supportive	4.5
Earning trust	22.7
Getting patient alone	31.8
Making patient feel safe	13.6
Gather additional information	
Asks about tattoos	4.5
Need hard evidence to pursue issue	13.6
Questions focus on presenting problem	77.2
Too busy to ask questions not related to presenting problem	13.6
N/A	13.6
Responsible for community referrals	
Nurse in charge	4.5
Physician	4.5
SANE nurse	4.5
Social worker	100

Table 4.13 (continued)

Barriers to readiness	
Fast pace of ED	36.3
Inconsistent EMR documentation about concerns	22.7
Inconsistent use and availability of interpretation services	4.5
Lack of HT awareness among staff	72.7
Limited knowledge on how to handle HT cases	18.1
No HT policy	18.1
Patients' reluctance to disclose concerns	4.5
Ways to improve readiness	
Consistent EMR documentation	40.9
ED staff training	95.4
HT EMR algorithm	13.6
HT policy	31.8
Procedural flow chart in pods	36.0

*Participants provided more than one response to address readiness.

Organizational Awareness

Organizational awareness of HT is critical for an effective response effort. Participants described system processes with limited ability to assist them in identifying trafficked individuals, placing systems at the precontemplation stage of change. First and foremost, 100% of participants believed that trafficked persons are seeking medical care in the ED. One participant said, "…I think sometimes they need medical attention, so their traffickers bring them to an ER" (NGH). Another participant referred to research and the intersection between HT and other forms of abuse. The participate stated that "…research shows that domestic assault and HT victims typically present multiple times to an ER without disclosing that they are either a victim of sexual assault, domestic assault, or HT, all of which you can deal with together" (GMH). When asked if trafficked individuals were coming to the emergency room at a suburban hospital, the participant

replied, “Yes, I guess I see a lot of, like people, coming in and you know, and they’re kinda standoffish and, they just don’t wanna talk very much. And there’s some that come in and they’re just like, they won’t say anything but the other person will say stuff for them” (HMH). Another participant at HMH agreed, “I think we’ve seen some. They just haven’t identified themselves.”

Ways of working within the organization. Findings showed that ways of working in the ED varied, meaning that 59% of participants reported that staff might feel comfortable assisting certain vulnerable populations but not others, while 41% believe their colleagues felt comfortable working with various vulnerable populations. Since HT might present or intersect with other forms of abuse, it is essential that this issue is not siloed to increase the identification of suspected HT cases. Sexual assault cases, for example, are often siloed based on participants’ responses. Participants said that sexual assault cases are often handled by staff with more expertise in the area and by Sexual Assault Nurse Examiners (SANE). A physician commenting on other physicians said, “I’ve heard several say that, no, I wasn’t trained to do that. I don’t want to do that. Cause they had SANE nurses that did everything” (GMH). According to a SANE nurse, “…if you’re not a sexual assault nurse other people are very hesitant and nervous to deal with them. I think because of the legal ramifications, and that extends to nurses and doctors” (GMH).

In the smaller hospitals, such as HMH and NGH, participants reported staff were more likely to work across vulnerable patient populations. “You know, being a community hospital, I think you kind of, you have to be able to do a little bit of

everything. And everybody here kind of chips in as a team" (NGH). "No, we do not work in silos here. However, we now have SANE on call" (HMH).

EMR documentation. Another ED system at the precontemplation stage of change is EMR documentation because of inconsistent ways of documenting and highlighting concerns with vulnerable patient populations. The ED also does not use a HT code for EMR, according to one nurse (NGH). Specific to inconsistencies, participants reported documenting concerns in different areas of the EMR. This is problematic because ED staff do not have time to read through every patient's chart. A physician said, "We have what we call blue flag. You can write a note in there if you're suspicious. I don't have any problem putting it in the chart" (GMH-Adult ED). Yet another physician reported never documenting concerns (GMH-Adult ED). A nurse commented on documenting in EPIC, saying "we have a place that we can do quick updates, just like a free text, like you know, here's what's going on at this time. And like those, you don't see unless you, like open up that chart, like that encounter within the patient's chart and look through everything, which we're not supposed to do because of HIPPA" (GMH).

Gathering additional information. Gathering additional information is about asking questions beyond the presenting medical problem, such as histories listed on the HT indicator checklist. Overall, participants reported that it is not standard practice to ask questions unrelated to the presenting medical issue. Findings from the patient data collection process during intake, triage, and the medical screening confirm the participants' perception. As stated in Appendix B, Table 14.1, 77% of participants

indicated that they focus their questions on the present medical issue, unless there are suspicious of abuse or other concerns.

Interpretation services. Results demonstrate that interpretation services are available for non-English speaking patients. However, the type of service that is available to staff varies. ED personnel at GMH in the adult and pediatric ED have access to in-person interpreters, specifically for Spanish speaking and American Sign Language patients. Appendix B, Table 14.1 lists how participants use interpretation services with the majority (73%), using in-person services, followed by telephone services (23%). An interpreter commented on the ease of access to interpretation services provided at GMH, "…when they call you from the pods sometimes it's just, you kind of just show up, and sometimes they say we need you somewhere stat." A physician reported using in-person interpreters at GMH but when working at HMH, the participant needs to call interpretation service. "…we'll have a speaker phone and I'll have usually the [interpreter] on speaker" (HMH).

ED Personnel Awareness

A second emergent theme was ED personnel awareness of HT. Among the 22 participants, 55% stated that they had knowledge of human trafficking, although 58% of them stated that their knowledge was limited. All participants reported wanting training on human trafficking to enhance their awareness. One of the barriers to identifying HT, according to 73% of participants, was a lack of HT awareness among ED personnel.

Despite limited HT training, five participants discussed HT related suspicions with 4 adult and 8 pediatric patients. The participants who voiced concerns were clinical staff, 4

nurses and one physician. When suspicions were noted, 1 participant was at NGH, 2 at GMH-Adult ER, and 2 at GMH-Pediatric ER.

Human trafficking knowledge. When describing knowledge of HT, participants referred to sex trafficking. One physician said, "I had a couple of people in my residency who went over that pretty heavily with us, but you know, I think we're taught a lot about – if you were to take the portion of trafficking education we had, which you know, would be in single digit hours, certainly, 95% of that would be sexual trafficking of young females. You know, it's like you were saying, more disadvantaged population, Hispanic, you know, Spanish speaking population, all that kinda stuff, so like that's really not covered at all. Very little time devoted to anything aside from the sexual trafficking aspect of it" (GMH-Adult). A nurse with SANE training reported that ER nurses, in general, have limited awareness to identify HT, "My nurses have a bit more training but again, they've had specialized training. So, a regular ER nurse with no specialized training, no" (GHM-Adults and Pediatric).

A social work participant claimed to have knowledge about HT warning signs but not on how to proceed with follow up questioning of the patient. "I believe I have the knowledge to recognize it and identify it, but I remember just maybe a month ago, we had one where the physician thought it may have been human trafficking and I went up to our social workers who'd been here for longer and asked them, you know, what are the questions I'm supposed to be asking, how do I assess for this. And they said that they honestly didn't know either cause we haven't been trained in that" (GMH-Pediatric).

Handling of suspected HT cases. Despite limited to no training on HT, some participants indicated having suspected HT cases. For example, a pediatric nurse reported being involved in a case where staff called Immigration and Customs Enforcement (ICE) about a 13-year-old patient who said she was brought to the United States to marry a man. The participant spoke with the patient and said "…you're gonna be with your mom. You're gonna be safe. And she was like, no that's not why I'm supposed to be here. You can't take us away from here, like I'm supposed to marry him" (GHM-Pediatric).

In a satellite hospital a few years ago, a nurse experienced two suspicious cases involving children. With both patients, the same woman accompanied the children to the emergency room several months apart and her story changed about how she was responsible for the children. The participant reported the second incident to her supervisor. "I told my manager, It's the same women. I'm telling you something is not right with this lady." Months later, the participant said, "I saw on the news they busted a big [human trafficking] ring and they were, I just caught the tail end of it and of course I didn't remember what the lady's name was, but it was Hispanic women in the group that they had caught" (NGH). According to the participant, the news report showed a picture of the woman who accompanied the children as part of the HT ring.

Ways of Knowing

A third emergent theme focused on clinical practice knowledge. For instance, clinical staff learn about specific verbal and non-verbal signs to help identify vulnerable patients through their educational programs and training events. Clinical staff also develop a sense when something seems amiss with a patient through practice experience. An

emerging theme discussed by 41% of participants was when something seemed off with a patient. Participants also talked about warning signs they believe are indicative of vulnerable patients, including possible trafficked individuals.

Something seems off. Among participants, 41% referred to sensing something was wrong with a patient. Participants described various scenarios of when something seems off with a patient, which may require additional attention. A nurse supervisor reported, "I feel like I have had nurses come to me, I can't recall any specific incidents but I do feel like I've had nurses come to me and say, like maybe not go so far as to say, I think this was human trafficking but just say, This was just weird. Like something about this wasn't right" (GMH-Adult). Similar to the nurse at GMH-Adult ER, a nurse at NGH said, "It's just that feeling, like huh. Like you should know your kid's date of birth, at least the date of birth." A pediatric nurse commented on a way of knowing by the social worker assigned to the unit, "she'll look at our board and if something feels, like kinda off [sic] she'll even say, hey do you want me to go see so and so" (GMH-Pediatric). Furthermore, non-clinical ED personnel noted ways of knowing as well. "…I think it's more the, once you start seeing how the people that come with the patient, the way they interact and if you spent more time in there, that's when you start seeing, like there's something weird here" (GMH-Adults and Pediatric).

Patient warning signs. Participants identified several warning signs that cause suspicion that a patient might be vulnerable, as shown in Appendix B, Table 14.1**.** One of the most prevalent warning signs, mentioned by 36% of participants, was when the person accompanying a patient answers questions for the patient. One nurse said, "You

know, if they have someone with them that won't allow them to answer questions, they answer for them. They are uncomfortable of them going to another place without them being there. I mean, all that kinda ties into just control" (GMH-Adults). Another nurse reported that "When the other person in the room is doing all the talking, I get concerned" (HMH).

Participants discussed other warning signs, such as avoiding eye contact (23%), defensive body language (18%), and the patient who is unable to answer basic questions about themselves. A SANE nurse commented on a litany of warning signs, including "things like eye contact and even body language" as important indicators that the patient might be in a vulnerable position (GMH-Adult and Pediatric). A nurse at NGH expressed concern when a pediatric patient's parent/guardian is unable to provide basic information. "It's just that feeling, like huh. Like you should know your kid's date of birth, at least the date of birth."

Different Practice Techniques

Different practice techniques evolved as the fourth emergent theme. This overarching theme is comprised of three emerging themes: gathering additional information, EMS documentation, and interpretation services. Responses highlighted various techniques when assessing and treating patients that relate to the ED's policies and procedures, patient data collection processes, and clinical practices.

Gathering additional information. Similar to findings from the intake, triage, and medical screening observations, participants indicated that gathering additional information on a patient is often situational. Additional information consisted of HT

indicators, such as drug and alcohol abuse, mental health issues, and tattoos. A nurse commenting on runaway history of pediatric patients said that “it’s not a standard question” (GMH-Adult and Pediatric). She further stated, “It would be like, let’s say I have a 17-year-old who comes in and the police brought her in and she’s in DSS custody. I would maybe go; I would document that in my notes but that’s not a necessary question.” The response by a physician working in the GMH Adult ER concurred with the nurse’s statement. However, the physician indicated a lack of time to ask additional questions. “You know, drug and alcohol abuse, a little bit if it’s related to their presentation, but in all honesty with emergency medicine, you know, we’re, everyone from pregnancy to birth to I’ve got a 90 year old over here, and then you’re trying to cover the entire array of medical knowledge and everything, so the problem is you just don’t have time to, or don’t take the time to dive into all those histories.

A non-clinical participant also reported that gathering additional information is situational. “As a chaplain, a spiritual assessment is conducted with patients. If concerns arise, then social work is called” (GMH-Adult and Pediatric). The participant does ask about tattoos as a conversation starter. “Chaplains do narratives, we do story. So, a lot of times asking about a particular tattoo is a way to invite story.” The chaplain was the only participant who asked patients about their tattoos. A SANE nurse said that “sexual assault nurses know what tattoos are most prevalent in human trafficking” but did not discuss whether the nurses ask about the tattoos or document them in EMRs (GMH-Adult and Pediatric). The majority of participants (77%) stated that their questioning of patients is

related to presenting problems, unless there is a concern. Therefore, gathering additional information is not standard clinical practice.

EMR documentation. Clinical participants expressed inconsistent ways of documenting patient concerns in EMRs. A social worker said, "I don't feel like we get consistent training on how to document things, so really it's based on whoever you observe and how they document" (GMH-Pediatric). A nurse commented on social work documentation and indicated that "social work notes can be more graphic; they need to write everything down in Epic" (HMH).

A few participants commented on using blue flags in EMRs as an alert for other clinical staff. According to a physician, "We have what we call blue flag. You can write a note in there if you're suspicious. I don't have any problem putting it in the chart" (GMH-Adult). The physician also stated that "there are a lot of things that go under the blue flag like drug seekers and some people, I don't know, weird stuff like, they need an MRI but, you know, it gets marked on the chart, so if they have a flag you can actually see it." However, a pediatric nurse at GMH was not aware of the blue flag. While looking at a patient's EMR in EPIC, the participant said, "I'm trying to see where the flags are at. It's probably the FYI." A non-clinical participant used the term sticky note to denote the place where staff document concerns in EMRs. This participant also commented that "Sticky notes do not show up through multiple visit" to the ED (GMH-Adult and Pediatric).

Interpretation services. The final emerging theme under different practice techniques is interpretation services. As per the Language Services policy, S-050-49, and findings from site observations at GMH, ED personnel used interpretation services for non-English speaking patients. Participants, however, accessed these services using different methods. A nurse from HMH stated that staff at this site use the phone to access interpretation services. Another satellite site, NGH, a nurse reported, "We don't have physical interpreters here at this campus, but we can use our wow computer on wheels. We can bring that, an interpreter on that. So, we can talk directly to the patient with the interpreter." Another nurse from NGH indicated using the phone more for interpretation services.

Participants reported using iPads to access interpretations services too. An interpreter at GMH said, "iPads that we take to the floor come to the ER and all that, that's for other languages and not Spanish." Another participant from GMH commented on using the iPad but with no visuals. Then a third participant from GMH used the iPad but said, "Sometimes we have the iPad, it depends on the language and it depends on what time of day. Like the iPad is only available during certain hours and other than that we have to use the phones."

Systematic Improvements

The final emergent theme is systematic improvements based on participants' perceptions to enhance the ED's readiness for change. Systematic improvements focus on policies and procedures, patient data collection and documentation as well as clinical practices. Appendix B, Table 14.1 highlights barriers to readiness with limited HT

awareness among staff (73%) as the most cited barrier, followed by the fast pace of the ED (36%), prohibiting personnel to gathering additional information.

Systematic improvements encompass seven emergent themes that impact the three ED systems discussed in this study. Participants believe that improvements are necessary to increase standards of care for trafficked individuals seeking treatment.

Policies and procedures. Several participants discussed the importance of having a HT policy (32%), helping to structure a consistent response. In addition to a policy, 36% of participants reported the need for a procedural flow chart to give clinical staff direction on how to proceed if HT suspicions arise with a patient. A comment from a nurse encapsulates the recommendation for an HT policy, "But I think as, we're very policy-based here so it's like, I'm used to being told, if this happens, you do this, like in this order, this is who you report it to, this is what number you call" (GMH-Pediatric). A nurse from NGH discussed incorporating HT into existing policies and having a separate HT policy. "So I think like you said it's probably intertwining that human trafficking into the vulnerable population somehow and that becomes part of that policy. I mean, you could separate it out into a human trafficking policy by itself and it may be large enough that you need to do that, but I would think having some sort of policy surrounding what we do and handle it."

A GMH pediatric nurse recommended a HT protocol with flow chart to clearly outline how to follow up on HT concerns. This recommendation was echoed by a GMH physician who went into detail about how the flow chart should look to grab the attention of ED staff. "…we've got a million different things all over the place and so even if it

were like, simpler is better, bigger words are better so, you know, even if there was a flow chart, you know, these three to five things, hey look out for X, Y, Z, if you're concerned call this number, you know, it has to be simple and easy cause if you get, you know, something like in this paper, no one's ever read that." Then a GMH pediatric social worker repeated the need for a flow chart to understand what steps to take when staff suspected HT. A social worker at NGH also would like to see a HT protocol but one with a focus on rural hospitals.

EMR documentation. Findings showed that 41% of participants reported inconsistent ways of documenting concerns in EMRs, an issue that might prohibit the identification of trafficked individuals. A pediatric nurse stressed the importance of consistent documentation, "There's multiple ways of doing that in Epic, and so I think just, like the consistency of everyone doing these type things in the same place would be, you know, like helpful just to make sure" (GMH). A non-clinical participant reported that some non-clinical staff do not have access to EMRs to document concerns, yet staff talk directly with patients. Therefore, vital information about a vulnerable patient might be missing. "That's why I say, when I was a chaplain upstairs, I could document, I had this conversation, here's how it went. I have no access to do that, which is just crazy to me. Cause we're kinda the front line" (GMH-Adult).

Some participants indicated that an EMR algorithm would assist ED personnel in identifying HT patients. According to a nurse, "Yeah, and you could have some kinda algorithm in there like that. I think that's not a bad way, it would trigger like a, we have like a, yeah there're alerts or best practice advisory sort of some sort of advisory that

maybe you need to ask these follow up questions" (NGH). When pressed about what a best practice advisory would entail, the participant said, "Yeah, sometimes it'll popup and say, you know, there's information missing or, you know, there's even sorta, there's protocols or things that you should alert, like it's an alert almost, it pops up. A physician also commented on the need for an algorithm, stating "Yeah, some sort of an algorithm, you know, would be helpful to, yes say, hey if you suspect this call this number" (GMH-Adult).

HT knowledge. Overwhelming, participants across job categories reported the need for HT training to increase awareness. A non-clinical participant said that one of the barriers to HT identification was "Not knowing the signs, that's the big thing" (HMH). The participant further indicated the need for all ED staff to have training. An interpreter at GMH suggested that her department would like training on HT warning signs. A nurse at NGH shared the same sentiments with the other participants and said, "I think we just need more education. On like signs to look for and, like you mentioned the tattoos, didn't have a clue about that. So now if we see that we'll know that that's a sign that we could identify." Similar to the aforementioned statements, a pediatric social worker at GMH commented that "But I think we're gonna need more education with the trafficking, cause this is just as significant if not worse."

Participants recommended in-person and computer-based trainings to improve ED personnel's awareness. The type of training varied by job category with physicians indicating a preference for computer-based training because of their schedules. A GMH-Adult physician suggested that other physicians would be more likely to take part in

computer-based trainings. The participant further indicated that the ED leadership would get more resistance from physicians if HT trainings were face-to-face. Physicians were the only job category that recommended only computer-based training.

Participants in other job categories would like a combination of training modalities. For example, a GMH chaplain stated that the training should be face-to-face to help staff connect with the issue. Comments from a chaplain at NGH were similar to the GMH chaplain's but focused on combining computer-based training and in person. "I think it would serve well to use a video course to teach terminology, just your general basic kinds of things. But I believe that it would be necessary to at least have an hour in a group setting in a classroom setting where people could intervene with an "expert" and be able to ask questions, maybe talk through a scenario, you know, general update kinda questions that come up, and have the benefit of hearing input from others and the questions that they ask. Nothing beats, when it comes to education training, nothing beats face-to-face. We're going overboard with some of that computer stuff" (NGH). A non-clinical participant from HMH also suggested in-person training with visuals, so the material would resonate with staff.

Similar to other nurse participants who commented that in-person training is necessary, one nurse expanded on the importance of multiple trainings. "I feel in-person training would be best. I think it'd have to be offered multiple times, and by that I mean not just one time. We had Jennifer Combs from Spartanburg come and speak but she was only here for about an hour and it was only one day, and it wasn't – it was hard if you

worked that day or something. So I would say, for example, our staff meetings, we have one at 7:30 in the morning and we have one at 5:30 at night, so it's people who gives nightshift an opportunity to come, and it's offered multiple times, not just one time. So, I think an in-person training is extremely important. I think the question/answer situation is also extremely important. And multiple times offered.

Gathering additional information. Participants expressed difficulties with gathering additional information and recommended safe places and ways of tracking patients from one site to the next. As for safe places, a pediatric nurse discussed a method being used at another hospital in Georgia where a patient is given a cup for a urine sample, along with a dot sticker. The patient then places the urine sample in a two-way box for the nurse to collect. If a dot is on the urine sample, the nurse consults with the patient before he or she returns to the treatment room. The participant said at GMH there is no safe place to put urine samples. Patients bring them back to their room and then the nurse takes it. The participant recommended another option, "I wish we had a place, like when we got people to give lab samples that there was like a little safe you could put it in, you know what I'm saying? So, they didn't have to bring it back out, because if people knew we were doing this little thing with the dot, then again those are all things that people, that those people will start picking up on. If that makes sense" (GMH). A GMH and HMH physician also touched on safety, stating that the ED needs a safe place to take a patient when attempting to gathering additional information, since the trafficker might be with the patient.

A nurse at a satellite hospital commented that EMRs show the various ED sites where patients seek medical care. However, a red flag is not created in the chart. The nurse recommended that multiple visits should create a red flag in EMRs, so ED personnel are prompted to ask questions. “You know, cause there’s people that do that and it’s not because they’re being trafficked, it’s because they’re looking for medications. So, you know, how do you alert that this child’s been taking to North Greenville and then two weeks ago they were taken to Oconee or a month ago they were taken to, you know, we can see that. You can see that in your record but it doesn’t necessarily mean, it doesn’t create a red flag. The doctor would just look and go, oh okay well they were seen here, and they were seen here, so that doesn’t sort of trigger, you know, maybe that’s something that needs to trigger in the background” (NGH).

Interpretation services. The final recommendation under systematic improvements pertained to interpretation services, specifically with cultural norms and interpreters’ inability to see patients when staff use certain types of equipment. As for cultural norms, participants discussed that ED personnel need a better understanding of cultural norms. One participant stressed that cultural norms might present as a trafficking red flag, especially when a male speaks for a female patient. The participant said, “And we have a lot, like you know, people from Guatemala where you have the male sometimes to speak more because he’s the one that speaks more Spanish [meant English] than the female because he’s been exposed to the bigger city…” (GMH-Adult and Pediatric). A pediatric social worker also spoke about the importance of understanding cultural norms. “And then also the cultural difference, like this mother who’s from Romania was super

abrasive, asked me why I was asking stupid questions. But that's, like the way she was presenting was pretty common for her culture. So, knowing that was helpful instead of me being offended, like just knowing that this is how a lot of women in her culture present, so. Yeah, the language, just different cultures, that all creates different barriers in of themselves" (GMH).

Satellite hospitals do not have interpreters onsite, and therefore, use an iPad or telephone for interpretation services. A nurse at a satellite hospital claimed that this is an issue because staff mainly use the telephone. Another nurse indicated that staff should use the iPad at satellite hospitals with visuals instead of the phone, so the interpreter can pick up non-verbal signals.

Thematic Map

The Thematic Map in Table 4.1 displays the five main, diamond-shaped themes, each theme's level of readiness based on the adapted TTM framework, and how the themes relate to one another (Maguire & Delahunt, 2017). The overarching theme was organization awareness, meaning the ability of the ED's current structure and systems to respond to HT. Organizational awareness is at the precontemplative level, since a HT response is not represented in the ED's structure and systems. This theme impacted and is affected by the ED personnel awareness theme and the different practice techniques theme.

Moving counterclockwise, the next theme is ED personnel awareness. Participants reported limited to no HT awareness, placing this theme at the precontemplative level. Among participants, nurses reported having more awareness of HT, specifically sex

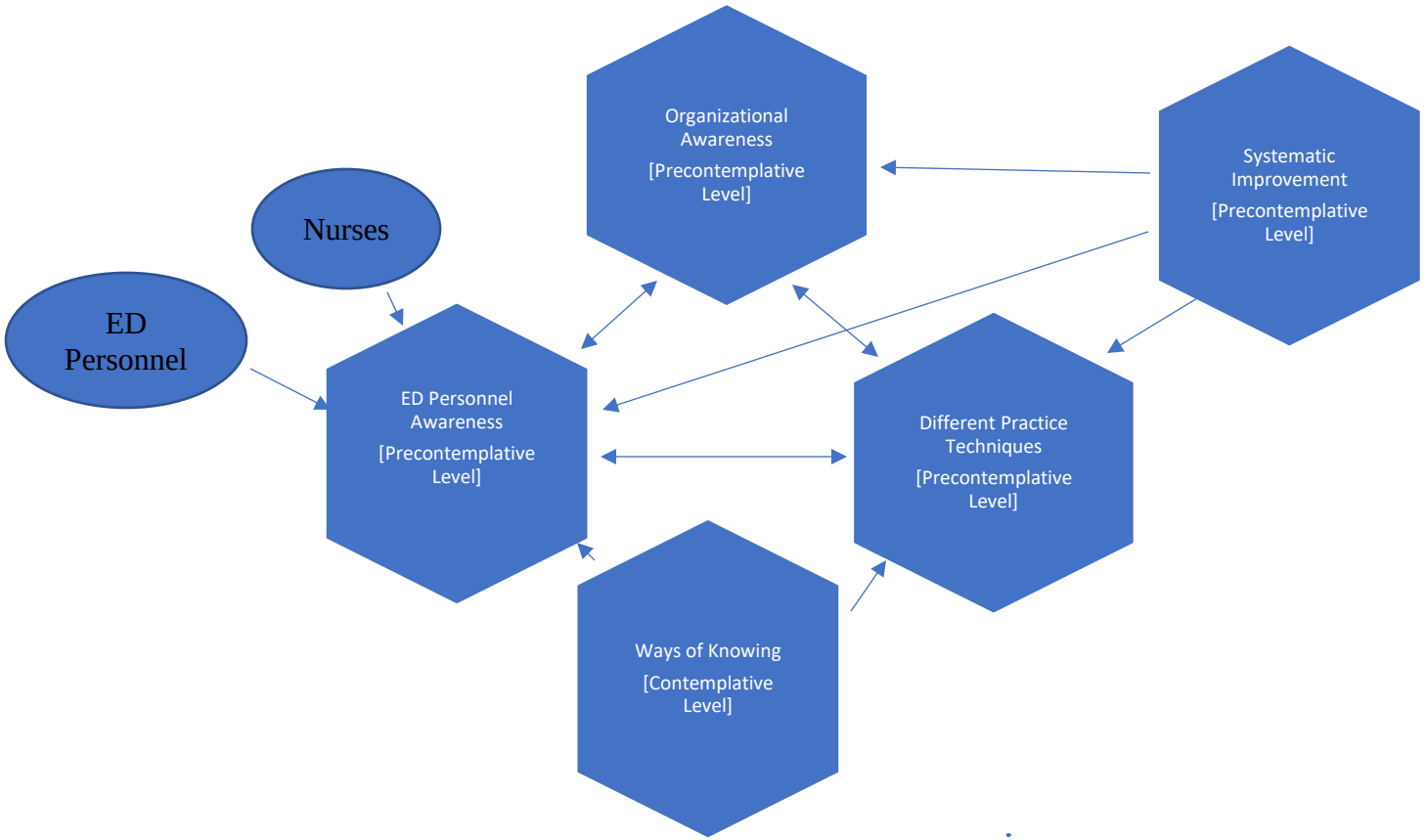
trafficking, than other ED personnel. Therefore, the nurse's icon is closer to the ED personnel awareness theme yet represents a smaller job category than the larger ED personnel icon, which includes the remaining 7 job categories of participants in the study. The nurse and ED personnel icons are unidirectional, representing variations of ED personnel awareness.

As a result of limited HT awareness and training, ED personnel relied on current ways of knowing when suspicions arose with a patient. Ways of knowing is the third theme on the map and impacted awareness and resulted in varying practice techniques, in terms of questions asked of at-risk patients and the documentation of concerns in EMRs. Among participants, 86% discussed ways of knowing when treating vulnerable patients and how this skill set might be applied to HT cases, despite limited to no HT training. The use of this skill set and growing awareness of HT, places this theme at the contemplative level.

The next theme is different practice techniques and was affected by organization awareness, ED personnel awareness, and ways of knowing. This theme encompassed current practice modalities of knowing when and how to gather additional information on a patient, how to document concerns in EMRs, and how interpretation services were implemented. This theme is at the precontemplative level, since formal organizational processes to respond to HT are not in place to assist ED personnel with the identification and treatment of trafficked individuals.

Figure 4.1

Thematic Map



The final theme was systematic improvement. This unidirectional theme directly impacts the themes of organizational awareness, ED personnel awareness, and different practices techniques. Participants were clear about necessary changes to improve the ED's readiness to respond to HT. At present, this theme is at the precontemplative level because steps for change are not being addressed.

Summary of Findings

Overall, findings showed that the ED's systems are at the precontemplative to contemplative stage of change, indicating that the ED is not ready to respond to HT in a consistent and effective way across its sites. First, Prisma Health does not have an HT policy to guide ED healthcare professionals. A review of 13 key system-wide policies that focused on vulnerable patient populations and standardized care found eight policies and procedures that intersected with HT. These policies would allow for the inclusion of an HT definition and procedures for suspected HT cases. The other 4 policies reviewed might assist in the identification and treatment of trafficked persons with increased organizational and staff awareness about HT and how it intersects with a multiple of presenting medical issues with patients.

Results from site observations of patient data collection processes suggested inconsistent implementation of key policies, standardized data collection, and clinical practices around safety questions as well as limited HT indicators being asked of patients, specifically during triage and the medical screening evaluation. Standardized data collection in the ED did not include HT indicators. Rather, healthcare professionals asked

patients a set of standardized questions, and if the situation warranted additional information, some HT indicators were addressed based on the presenting medical problem. The HT indicators addressed were not intended to assess for HT but other issues, such as mental health histories, that might intersect with the medical issue at hand. The most frequently asked HT indicator during the triage process for adult patients was about their history of multiple drug use (36%). Mental health disorder was the most common HT indicator during triage for pediatric patients.

Observations of the patient data collection processes suggested that patients were less to be asked HT indicators during the medical screening evaluation than triage. Of the 13 adult patients observed, 3 were asked about mental health disorders and 2 about their history of multiple drug use. Among the 11 pediatric patients observed, one parent was asked about the child's genital pain. In total, three HT indicators were addressed during medical screening evaluations.

The site observations also showed inconsistent policy implementation and clinical practices with safety questions asked during the triage process at three of the ED sites. Among the 22 adult patients observed, the triage nurse asked 88% of adult patients SQ1 and 92% SQ2. Triage nurses asked 59% of pediatric patients' parent/guardian SQ 1. Across sites, if a nurse asked SQ 1 at GMH-Adult ER of an adult patient, he or she asked SQ2. However, that was not the case at HMH where 73% of adult patients were asked SQ 1 and 60% SQ2. Overall, findings indicated that the ED's patient data collection processes were at the precontemplative level, meaning that this system is not ready to respond to HT across ED sites, since current standardized questions do not address HT.

The final data collection process consisted of semi-structured interviews with a diverse cross-section of ED personnel that included a total of 22 clinical and nonclinical staff. Semi-structured interviews sought participants' perceptions of the ED's current readiness to respond to HT. Participants reported that the ED's systems, including personnel, have limited awareness of HT, making it difficult to identify trafficked persons. Results showed the emergence of five overarching themes. The five themes are listed in Table 4.14, along with the percentage of participants from each site who discussed issues pertaining to the theme.

Table 4.14

Emergent Themes as a Percentage of Participants by ED Site

	GMH-A (N=10)	GMH-P (N=6)	HMH (N=2)	NGH (N=4)
Organizational Awareness	100	100	100	100
ED Personnel Awareness	100	100	100	100
Ways of Knowing	90	83	50	100
Different Practice Techniques	90	83	50	100
Systematic Improvements	100	100	100	100

CHAPTER FIVE

DISCUSSION

Overall, results indicated that the ED's structure and systems were not ready to respond to HT. Findings from this case study were consistent with a study that found 18 South Carolina hospitals had limited capability to identify and care for trafficked individuals (Armstrong, Greenbaum, Lopez, & Barroso, 2019). Implications of the results from this study highlight barriers to identifying trafficked individuals within a healthcare setting's structure, systems and among its personnel. Furthermore, findings provide a more in-depth understanding of how the ED might improve its HT response based on personnel working within the system's parameters.

In this chapter, results are discussed in conjunction with the research questions and the adapted transtheoretical model's (TTM) stages of change construct that acted as a guide to explain the ED's readiness. A discussion ensues about the study's findings, highlighting the current stages of change for the ED. Finally, recommendations are provided to enhance the readiness of the ED's structure and systems, geared toward moving the ED from low levels of readiness based on its current stages of change.

Conceptual Implications

Prochaska, Prochaska, and Levesque (2001) asserted that the TTM was a framework to integrate theories of change. The stage of change construct provides a conceptual map of how the ED might move from low levels of readiness within its structure and systems to developing and implementing standards of care to effectively respond to HT. Findings demonstrated that the ED's observed sites and systems have a limited capacity to identify

trafficked individuals. The inability to identify trafficked individuals impedes treatment options by clinicians**.** Figure 5.1 demonstrates the ED's current levels of readiness within its systems and for each site. Results from this study were based on the following research questions:

1. What is the readiness for change within the ED's systems to respond to HT that include policies and procedures, patient data collection, and clinical practices?

2. What is the readiness for change within the ED's systems to respond to HT across ED sites?

3. How does system readiness to respond to HT vary across ED sites?

4. What are ED personnel's perceptions of system readiness to respond to HT across job categories?

The intent of the first, overarching research question was assess the capability of the ED's systems to respond to HT. Results indicated that two of the three investigated systems, policies and procedures and patient data collection, were at the precontemplation level, meaning the ED has not taken steps to incorporate HT into its existing systems. As for clinical practices, the ED offered a one-time, in-person HT training for personnel at all sites, which some participants attended. Since an effort was made to train staff, clinical practices are at stage 2, the contemplation level. The ED also created a human trafficking task force at GMH that has raised awareness among its members from various ED sites. However, the task force has not recommended formal changes to the ED's systems.

Overall, participants across job categories reported low levels of organizational readiness to respond to HT, yet all of participants believed trafficked individuals were

coming to the ED for medical care and 5 participants discussed HT related suspicions with 4 adult and 8 pediatric patients. Perceptions of low levels of organizational readiness were consistent with evidence from the policies and procedures review as well as site observations of patient data collection and clinical practices.

All of the participants stressed the need for HT training to enhance the identification of trafficked individuals. Of the 22 participants, 50% had some HT within the past two years. Among the participants who had HT training, there were 9 nurses, 1 physician, and 1 Chaplain. Previous scholarship emphasized the importance of HT training to increase awareness of HT warnings and how to respond to trafficking cases (Armstrong, Greenbaum, Lopez, and Barroso, 2019; Baldwin et al., 2011; Shandro et al., 2016). In addition to scholarship, the American College of Emergency Physicians (2016) and the American Academy of Nursing on Policy (2018) have policy statements on HT that emphasized increased awareness and training for healthcare personnel.

Findings discussed below are organized by the ED's systems and address the study's research questions. Many of the study's findings overlap with the ED's systems and sites and are described in detail.

Findings for Policies and Procedures. Consistent with other studies, this study found that the ED does not have systemwide policies and procedures that address HT, and therefore, no variation across ED sites. The absence of HT protocols to guide healthcare personnel prohibits effective identification and treatment of trafficked individuals (Recknor, Gemeinhardt, & Selwyn, 2018). Specific to South Carolina hospitals, Armstrong, Greenbaum, Lopez, and Barroso, 2019) reported that among the 18

hospital facilities represented in the study, 15 did not have an official, written policy on HT and 3 participants were unsure.

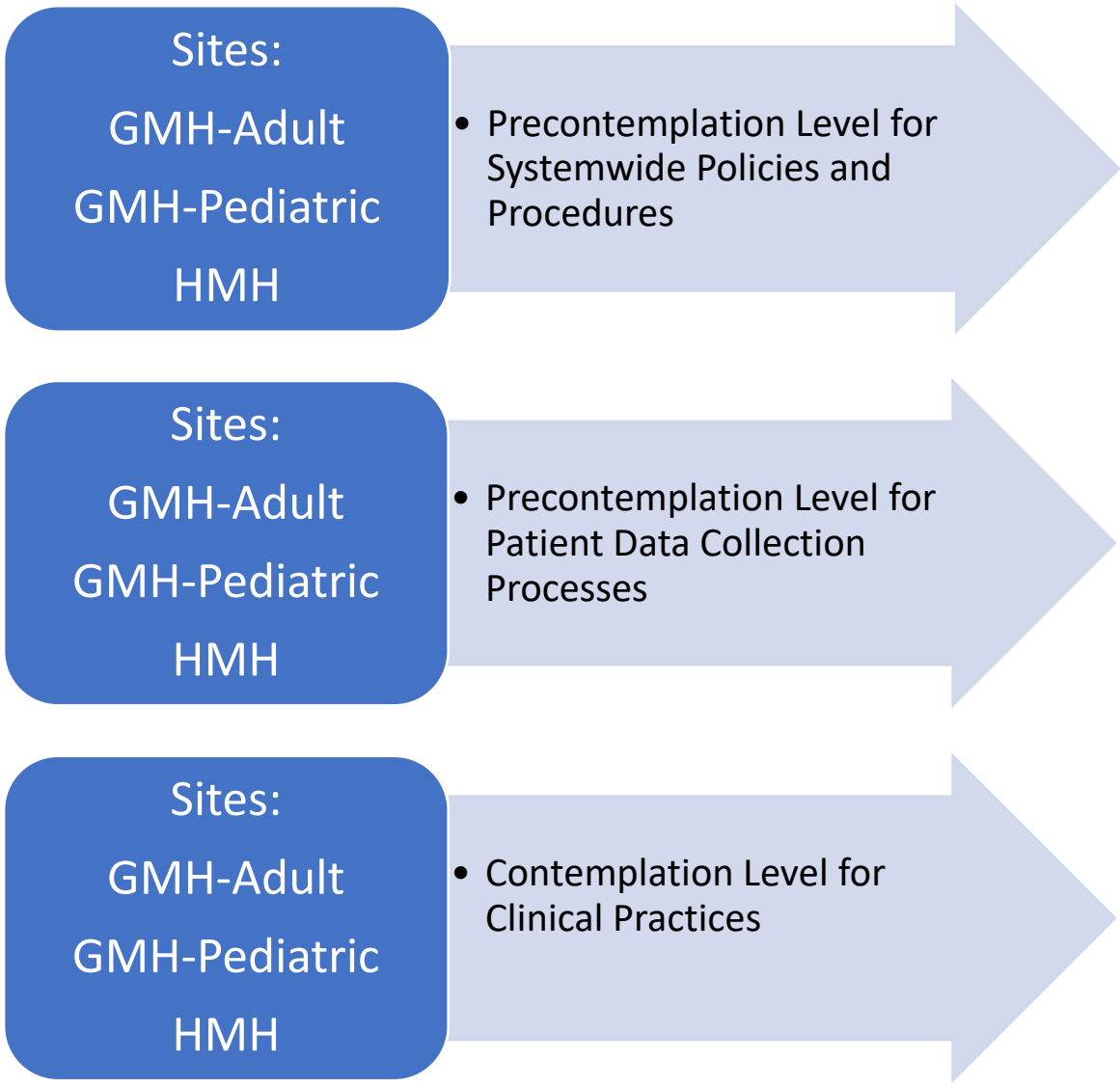
When participants were asked about recommendations to improve the ED's current systems to respond to HT, 32% suggested a HT policy and 36% a procedural flow chart that explained how to handle suspected HT patient cases. Recommendations from other studies also called for protocols and procedures to assist medical providers in identifying trafficked individuals (Armstrong, Greenbaum, Lopez, and Barroso, 2019; Lederer & Wetzel, 2014; Recknor, Gemeinhardt, & Selwyn, 2018).

A few hospital facilities have HT protocols that may act as a guide for other healthcare settings (Alpert, Ahn, Albright, Purcell, Burke, & Macias-Konstantopoulos, 2014; Genesee County Medical Society, n.d.), while some studies examined the development and implementations of HT protocols (Schwartz, Unruh, Cronin, Evans-Simpson, Britton, Ramaswarmy, 2016; Stoklosa, Dawson, Williams-Oni, & Rothman, 2017).

HEAL (Health, Education, Advocacy, Linkage) trafficking researchers, Baldwin, Barrows, and Stoklosa (2017), stressed incorporating HT into existing protocols that address other forms of violence in an effort to streamline training and clinical practice processes. Specific recommendations on how to incorporate HT into the ED's policies and procedures is presented in the next section of this chapter.

Figure 5.1

TTM Stage of Change for ED Sites and Systems



Findings for standardized patient data collection processes. Based on ED site observations, findings indicated that current standardized patient data collection processes are ill equipped to assist ED personnel across sites in identifying and treating trafficked individuals.

Lederer and Wetzel (2014) advised that ED personnel "should be alert for the most common physical and psychological conditions and symptoms these victims experience…" (p. 87). Results from the present study showed that few questions related to HT indicators were part of the patient data collection process. During the triage process with adult patients, ED personnel asked questions related to 7 of the 25 HT indicators being assessed. The most frequent HT indicator asked of adult patients was their history of multiple drug use (36%). For pediatric patients, 18% were asked questions about mental health. In general, patient data collection did not cover any other possible HT indicator for pediatric patients.

Questions related to HT indicators during the medical screening evaluation were less likely to be asked than during triage. For adult patients, 23% were asked about mental health and 15% about their history of multiple drug use. Genital pain was the only HT indicator asked during the medical screening evaluation for one pediatric patient.

Researchers recommended that ED personnel assess for HT indicators when concerned that a patient might be at risk of abuse or violence (Shandro et al., 2016). Specific to the medical screening exam, researchers stressed the need for careful documentation of any signs of abuse as well as tattoos and piercings. Another study echoed the recommendations of Shandro et al. (2016) that physical injuries from violence

might be a trafficking red flag, requiring ED personnel attention, along with histories of multiple abortions and sexually transmitted diseases (Lederer & Wetzel, 2014).

For research question 2 on the level of readiness for change across ED sites and research question 3 on how readiness varies across sites, findings demonstrated that each site was at the precontemplation level for policies and procedures and patient data collection, as evidenced in Figure 4.1. Each site adheres to the ED's standardized systems, resulting in low levels of readiness, since the ED has not incorporated HT into its policies or designed HT screening questions in its patient data collection processes. Currently, these systems are not designed to help ED personnel identify trafficked individuals seeking medical care, and therefore, limit treatment options.

Findings for clinical practices. Part of the standardized data gathering process during triage includes safety questions to assess for domestic violence. However, this study found through site observations that all patients/parents or guardians are not asked SQ1 about feeling safe in their home. Among adult patients, 88% were asked SQ1 and 59% of parents/guardians. As for SQ2 about feeling safe in your relationship, ED personnel asked 67% of adult patients. When asked, researchers agree that safety questions might serve to identify trafficked individuals (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Chisolm-Straker et al., 2016), although adding a third safety question about feeling safe at work might help to identify labor trafficked individuals. Chisolm-Straker et al. (2016) emphasized that asking patients about their living and work situations might play an important role is identifying trafficked individuals.

Different practice technique emerged as a theme from the semi-structured interviews, addressing research question 4. Participants confirmed site observation findings and commented on the number of questions required for EMRs, along with the limited time to gather additional information. All of the clinical participants reported asking patients additional questions about their physical and mental health as well as histories is based on the presenting medical issue. Specifically, 14% of participants reported being too busy to ask questions unrelated to the presenting issue. In a study with HT survivors, one of the findings was limited time with the healthcare providers and building rapport (Restore, 2019), whereby lessening the likelihood of identification. With increased HT training, however, ED personnel would be more likely to recognize HT warning signs and proceed with follow up based on ED procedures.

Another finding under this theme pertained to inconsistent EMR documentation of concerns. Participants (23%) mentioned this issue as a potential barrier to identifying trafficked individuals. Shandro et al. (2016) emphasized the importance of medical documentation for suspected HT cases, specifically in the history section, focusing only on relevant medical facts and supporting details. Documentation of HT concerns should be part of the ED's HT training efforts and included in a HT protocol.

This study also found inconsistent use and availability of interpretation services. As per the Language Services policy, S-050-49, non-English speaking patients do have access to interpretation services. Participants, however, stated different methods of accessing language services, especially at satellite hospitals. To access language services, participants used an iPad with or without the visual component and a speaker phone.

Since in-person interpretation services are not feasible for all languages, the HT protocol should address the inconsistent access to language services and require ED personnel to use the iPad with camera turned on to help identify HT warning signs.

Finally, ways of knowing as a theme that emerged based on participants' practice experience with vulnerable patient populations. Participants discuss patient warning signs, as shown in Table 4.13, that raised concern about a patient's situation. The identified warning signs are indicators of a patient's vulnerability and might help to identify trafficked individuals as well. Training is highly recommended to help ED personnel apply their current knowledge and practice expertise to respond to HT.

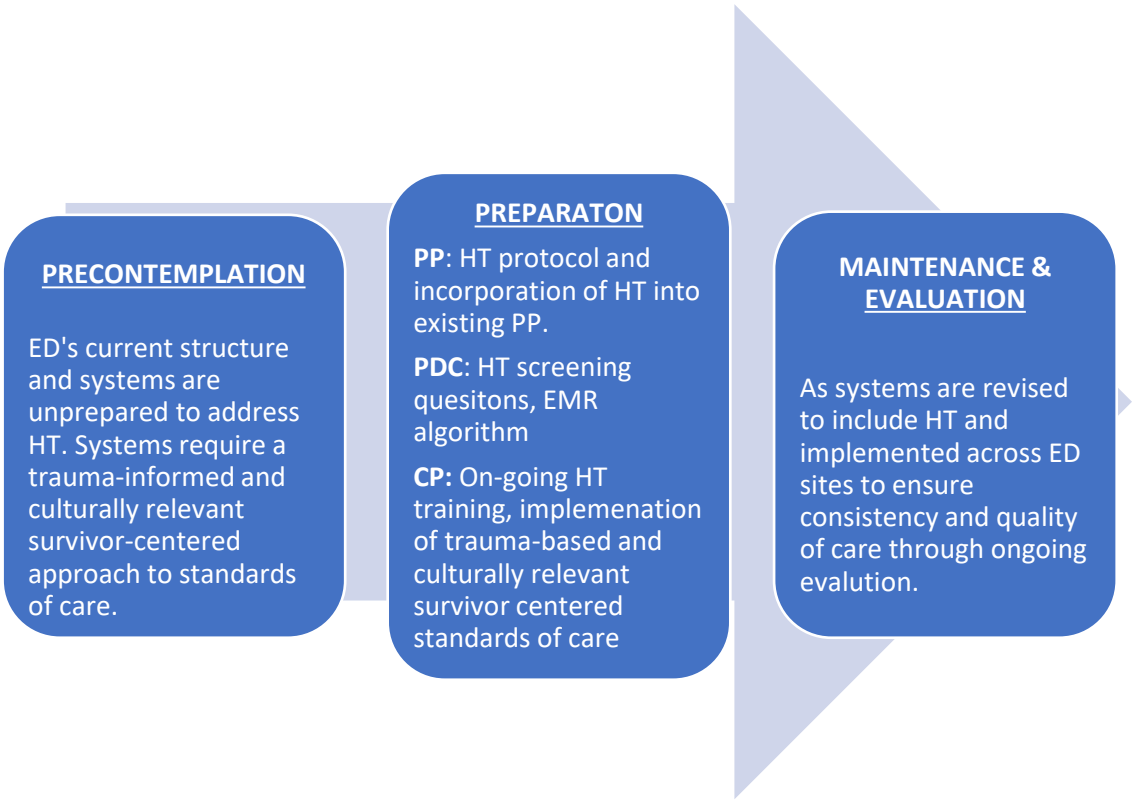
Recommendations

The ED personnel are in a unique position to identify trafficked individuals seeking medical care. As results from this study showed, HT training is necessary to help ED personnel recognize warning signs, document concerns in EMRs, and know how to respond to suspected cases. Among participants, 95% recommended on-going HT training to increase awareness and to ensure a consistent response. Along with HT training to improve readiness, participants recommended consistent EMR documentation of concerns (41%), an HT algorithm (14%) in the EMR system to alert ED personnel of HT red flags, a HT policy (32%), and a procedural flow chart (36%) to guide ED personnel on HT suspected cases. Figure 6.1 highlights suggested improvements by participants to increase the ED's readiness, along with best practice recommendations from the literature that include trauma-informed and culturally relevant survivor-based standards of care (ACEP, 2016; Baldwin, Barrows, & Stoklosa, 2017). Figure 5.2 focuses

on three of the five stages of change to show the progression from precontemplation to preparation for changes within the ED's system to maintenance/evaluation of systematic changes across sites. First and foremost, it is recommended that the ED establish an ongoing HT training system and develop a HT protocol.

Figure 5.2

Evolution of Systematic Changes to Respond to HT



Note: Under preparation, PP stands for policies and procedures, PDC for patient data collection, and CP for clinical practices.

Recommendation #1: Establish Trauma-Informed HT Training

The ED needs to mandate on-going trauma-informed HT training to all ED personnel. HT training needs to encompass the different forms of trafficking and warning signs to help staff identify trafficked individuals. The training also should include how and where staff should document concerns in the EMR to ensure consistency across sites and job categories. The ACEP's (2016) policy statement stressed that emergency clinicians received training on the documentation of HT. At present, ED personnel in this study do not have the ability to appropriately respond to HT cases.

Results from this study indicated participants' interest in on-going HT training. Findings also confirmed pervious research on the need for increased HT awareness among medical professionals (Goldberg et al., 2017; Egyud et al., 2017; Sinha, Tashakor, & Pinto, 2018) as well as by professional associations (ACEP, 2016; Speck, Mitchell, Ekroos, Sanchez, & Hilfinger Messias, 2018).

Recommendation #2: Create a HT Protocol

The ED needs to create a HT protocol. Participants recommended procedures to guide them when they suspect a patient might be vulnerable to HT. The creation of a HT protocol would increase readiness to respond to HT within the ED's structure and systems.

Researchers advocate that healthcare facilities develop protocols to deliver appropriate healthcare to trafficked individuals (Baldwin, Barrows, & Stoklosa, 2017; Rollins, Gribble, Barrett, & Powell, 2017; Stoklosa, Dawson, Williams-Oni, & Rothman, 2017). Establishing a HT protocol and incorporating HT into existing policies and

procedures will allow the ED to move from a precontemplative level of readiness toward the maintenance and evaluation stage. In a study that reviewed 30 existing HT protocols, Stoklosa, Dawson, Williams-Oni, & Rothman (2017) proposed several components for a comprehension guide. The following components includes those recommended by Stoklosa, Dawson, Willimans-Oni, and Rothman (2017 as well as findings from this study. The revised components consist of : 1) a list of evidence-based, practice- informed HT indicators; 2) a formal definition of HT and types of HT; 3) trauma-informed and culturally relevant screening approaches; 4) the chain of command for reporting suspected cases for clinical and non-clinical ED personnel; 5) referral contact information for community resources; and, 6) follow up best practices for identified HT patients.

Recommendation #3: Develop a HT Algorithm

The ED needs to develop a HT algorithm in EMRs based on HT red flags. A HT algorithm would alert ED personnel to assess the patient for being at-risk of HT. HT indicators should be incorporated into existing screening questions, eliminating the need for separate HT screening. Egyud et al., (2017) demonstrated that a treatment algorithm was an effective strategy for identifying HT as well as other forms of abuse.

Recommendation #4: Incorporate HT into Existing Policies and Procedures

The ED needs to incorporate HT into existing, key policies and procedures because of its intersection with other issues affecting vulnerable patient populations. This is another step to improve the ED's readiness for change. Based on a review of 13 systemwide policies and procedures during this study, the following sub-

recommendations detail how 8 policies might incorporate HT. The name of the policy is highlighted in bold print.

Documentation of acute nursing care. The Documentation of Acute Nursing policy states that the nursing team is responsible for patient data collection and the admission assessment documentation in the electronic medical records. As part of the patient data collection process, nursing team members ask patients an array of questions, including screening questions on alcohol and/or substance abuse as well as for abuse and/or neglect.

Under Section 1.b. item 5, in the Procedure Section, the screening for abuse and/or neglect is listed. Human trafficking should be added to this section. Currently, triage nurses ask patients two safety questions to assess for abuse and/or neglect. One question is, "Do you feel safe in your home?" The second safety question is "Do you feel safe in your relationship?" For patients who are 14 years and up, a safety question to assess for labor trafficking might be, "Do you feel safe at work?" If a patient answers in the affirmative or if the nurse senses that something is not right, additional human trafficking questions can be asked once the nursing team is able to get the patient alone. See sample human trafficking screening questions in Appendix H**.** The human trafficking screening questions should be an appendix to this policy.

Language services. For Language Services (S-050-49), under Procedures, Section III, part A, over 200 language services are available for the ED via video, in-person, and telephonic interpreters 24 hours a day, 7 days a week. However, only Greenville Memorial adult and pediatric emergency rooms have limited in-person language services,

such as the Spanish language and American Sign Language. Emergency rooms for the satellite hospitals rely on video and telephonic interpretation services. If a patient has limited English proficiency, the clinician in charge must contact interpretation services by calling 5HOLA from any Prisma Health phone or by completing the language identification card under Plexus, on Prisma Health's intranet. A patient's primary language is documented in the legal medical record.

Language services for suspected or confirmed human trafficking cases, should be added to Section III, part A. With these cases, interpretation services needs to be face-to-face, when possible, or via video. This will allow the interpreter to note non-verbal or cultural cues to assist the clinician in a more effective medical interview and evaluation. Non-verbal and cultural cues that might assist in the identification of trafficked person will most likely be missed with telephonic interpretation services. For satellite hospital emergency rooms, video interpretation is highly recommended.

Recognition and reporting of abuse and neglect of children and vulnerable adults. Policy S-050-55 focuses on identifying, treating, and reporting suspected cases of abuse and neglect as per South Carolina law. The policy calls for any allegation of abuse or neglect to be entered in the Prisma Health's reporting system and then lists suspected types of abuse under the policy statement. Suspected human trafficking, recognizing and reporting, should be added to this list. Next are definitions of abuse and neglect. Under the definition section, the various forms of human trafficking should be included, such as definitions for sex, labor, bride, and domestic minor sex trafficking.

Reporting for suspected or confirmed cases involving trafficked adults, is not required by South Carolina law. The adult patient has the right to self-determination, meaning the right to accept or refuse help. However, the clinician should make a verbal report of suspected or confirmed cases following chain of command procedures. No changes are necessary for reporting procedures for children, under Section II. Since child trafficking is a form of child abuse, clinicians would follow the current reporting procedure.

Patient monitoring during transfer within a facility. When healthcare professionals suspected concerns with a patient, they reported trying to get the patient alone to ask more direct questions. Policy S-050-096 addresses patients being transferred from the patient care area to another section within the facility. Under Procedure, Section II and in Appendix A, under Behavioral Status, are guidelines about patient transfers within a Prisma Health facility. It is recommended that both sections be amended to include the transport of a patient who presents with human trafficking warning signs without the person(s) who might have accompanied the patient to the emergency room.

Patient observation. Prima Health's policy on patient observation is meant to ensure the safety of patients who are cognitively impaired or who are not complying with safety instructions. Studies about human trafficking indicate an intersection between individuals with cognitive impairments and human trafficking (Polaris, 2018). This policy statement might be amended to include patient monitoring for suspected HT cases to ensure the safety of the individual and to determine how to proceed based on the situation, especially if the patient is removed from the patient care area for further questioning. The

policy should apply to patients with or without cognitive impairments. Under the Process Section, an explanation needs to be provided with steps on how to observe a patient when a clinician suspects or confirms human trafficking. Patient observation might be necessary if the clinical team is waiting for law enforcement or other agencies to assist the patient.

Abuse, neglect and reasonable suspicion of a crime on a Prisma Health property. Prisma Health seeks to ensure patient safety while receive care by preventing and prohibiting all forms of abuse, neglect, and harassment from staff, other patients, or visitors, as detailed in the policy statement. One of the definitions under the policy statement is unreasonable confinement, which pertains to a patient's ability to move freely without punishment. A trafficker might accompany a patient to a healthcare setting, based on research with human trafficking survivors (Baldwin et al., 2011; Polaris, 2018) and might complete paperwork and communicate with clinical staff, thereby controlling the trafficked patient during the healthcare visit (Baldwin, 2011). It is recommended, therefore, that the unreasonable confinement be amended to: "Limiting a patient's ability to move freely about as a mode of punishment" or control (p. 2).

Under Section C of the Procedure Section, Prisma Health will take steps to protect patients from allegations of abuse, neglect, or harassment. This section should be amended to specify how children and adults will be protected in the event of suspected or confirmed HT. Furthermore, Section D on reporting and responding to abuse, neglect, or harassment should include guidelines for staff on how to report and respond to human trafficking cases.

Emergency department triage. All patients entering the ED are assigned an Emergency Severity Index (ESI) level and given a Medical Screening Exam (MSE), based on the policy statement. At several Prisma Health ED locations, patient intake and triage are combined. Therefore, the triage nursing staff are often the first clinical staff persons to see a patient. The clinical impressions of triage nursing staff is critical for the identification of trafficked individuals. In the Procedure Section under Section II, is a definition for ESI Level II for high risk patients, along with examples like high risk situations. The high-risk situation should be amended to include human trafficking.

Next, in Section III of the triage process, under B, the nursing staff conduct a Quick Look. The focus of the Quick Look is on chief complaints and physical symptoms. The Quick Look should note suspicions of a patient being controlled. This section also should include steps for the removal of a patient from the accompanying individual of concern.

Sexual assault examination, child and adolescent. Healthcare professional must be aware that human trafficking might intersect with sexual assaults cases. Prisma Health's policy on sexual assault examinations provides a link to Lippincott's online procedures for sexual assault cases, co-developed and reviewed by the American Academy of Ambulatory Care Nursing (Lippincott, 2019). Lippincott's guidance indicates human trafficking as a related procedure.

According to Section VII under Procedure, a patient will be assessed for injuries. It is recommended that a section on assessing for human trafficking be included under the procedure guidance with a link to Lippincott's procedures for "Suspected human

trafficking, recognizing and reporting, ambulatory care" (Lippincott, 2018). Lippincott's procedure provides a list of screening questions to help identify human trafficking.

Sexual assault examination, adult. Prisma Health's policy on sexual assault examination for adults is similar to policy S-050-224 on sexual assault examination for a child or adolescent. For adults, it is Section VI under procedures that discusses assessing a patient for injuries and immediate medical attention. Assessing for HT should be added to this section as well. Like policy S-050-224 for children and adolescents, this policy should contain a procedural section on human trafficking with a link to the Lippincott procedural guidance, including screening questions.

Additional system-wide policies and procedures. Prisma Health has several policies with specific procedures for vulnerable patient populations to guide healthcare professionals. A few other policies are shown in Table 5.1 that might allow for the identification and treatment of trafficked individuals with increased organizational awareness about this issue. First and foremost, healthcare professionals need on-going training on human trafficking. This training needs to include how HT intersects with other vulnerable patient populations for effective policy implementation. For example, the Assessment/Reassessment of Patients might help with human trafficking identification as the healthcare professional continue to monitor a patient, while building trust. During the assessment/reassessment process, healthcare professional need to be vigilant to verbal and non-verbal cues by the patient.

Table 5.1

Existing System-Wide Policies to Assist in Human Trafficking Identification (*n* = 4)

Policy Name	Policy Number	Patient Population
Assessment/Reassessment of Patients	S-050-016	Adult and Pediatric
Management of Suicidal, Homicidal and/or At Risk for Violence Patients	S-050-037	Adult and Pediatric
Sexual Assault Anonymous Reporting, Adult	S-050-211	Adults
Opioid Stewardship Program	S-050-187	Adult and Pediatric

Policies that focus on other vulnerable patient populations also might assist with improving the ED's human trafficking response efforts. Since prior research (Hickle & Roe-Sepowitz, 2018; Polaris, 2018; Restore NYC, 2019) shows that trafficked individuals accessed medical care for mental health issues, including suicidal ideations, the policy on "Management of Suicidal, Homicidal and/or at Risk for Violence Patients" might allow for human trafficking identification, if the patient presents with behavioral health chief complaint. The "Sexual Assault Anonymous Reporting, Adult" policy allows a patient who is 18 and older and a victim of sexual assault to have forensic evidence collected without making an official incident report to law enforcement. Victims of sexual assault decide not to make official incident reports for many reasons. One reason might be as a result of being trafficked. Healthcare professionals, therefore, must be

aware of the possible intersection between HT and sexual assault and know when to ask screening questions to assess for trafficking.

The final system-wide policy that might assist with HT identification is the "Opioid Stewardship Program" with its focus on measuring and promoting safe use of opioids within Prisma Health. Opioid addiction is a public health issues that interfaces with human trafficking. In a National Academy of Medicine interview with Hanni Stoklosa (2019), she stated that half of the trafficked individuals in emergency rooms have an addition to an opioid. In Section A, bullet 9 of this policy, the objective is to identify rehabilitation programs within the community to help with reduction strategies. These collaborations need to tackle the parallel issue of opioid addition and human trafficking for effective strategies and treatment options. The Opioid Stewardship Program should not be a siloed program but one that addresses the multifaceted issues surrounding the opioid crisis, such as human trafficking.

CONCLUSIONS

The present study demonstrated that the ED's structure and systems are at precontemplative to contemplative stages of change, meaning all areas require improvements to effectively respond to HT. The American Medical Association (2017) highlighted significant barriers within the healthcare system, in general, that prohibit the identification of trafficked individuals. However, some healthcare facilities are beginning to recognize the issue of HT and are taking steps to enhance their systems. Prisma Health's Department of Emergency Medicine is at the forefront of this movement by allowing an in-depth case study of its structure and systems. With the implementation of

the recommendations set forth in this study, the ED will be better suited to respond to HT, moving from precontemplative and contemplative stages of change to the maintenance/evaluation stage of change, indicating a high level of readiness.

Limitations

This study had several limitations. First, the sample consisted of data from a single ED in a mid-size geographic area. The sample's readiness might differ from other EDs throughout the state and nation. Readiness might vary among EDs, depending on size, location, levels of HT awareness in a given community, and the allocation of resources in each facility for staff training and structural changes to better respond to HT. Despite potential variations, the study's organizing framework might assist other healthcare organizations in assessing the readiness for change within their respective systems.

Second, this study used an adapted TTM stages of change construct to qualitatively assess readiness. Research the incorporates additional TTM constructs as well as quantitative data will help to broaden the organizing framework to determine readiness for change for healthcare settings.

Third, the sample size of ED personnel participants was relatively small for each job category. Snowball sampling also posed limitations, since those with prior knowledge of or interest in human trafficking might have been more likely to participate in the study. Moreover, the experiences, clinical practice methods, and perceptions of participants might differ from other healthcare professionals within the ED as well as those working for other hospital systems.

Forth, the human trafficking indicators used for the observation checklist were based on a few studies (Greenbaum, 2016; Fang, Coverdale, Nguyen, & Gordon, 2018; Small, Morales, & Hefner, 2015; Varma, Gillespie, McCracken, & Greenbaum, 2015). These indicators may or may not capture characteristics of the general population of trafficked individuals, specifically since indictors are more reflective of sex trafficking rather than labor trafficking. As noted by Small, Morales, & Hefner (2015), the presence or absence of indicators does not verify or deny the possibility of HT. Rather, HT indicators raise concerns for further investigation.

Finally, time constraints based on long ED wait times prohibited following patients through the ED process from intake to triage to the medical screening evaluation. Rather, observations were conducted in ED process blocks, meaning three to four-hour intervals were spent in intake, triage, and the medical screening evaluation.

Despite the limitations, this qualitative case study allowed for the gathering of rich data to assess the ED's readiness for change that could not be obtained from strictly quantitative measures. This study also provided a readiness baseline for the ED to improve its existing structure and systems to respond to HT.

Future Research

As a result of limited research on the intersection between healthcare and HT, there are vast opportunities for future research. However, the identification of trafficked individuals is paramount for EDs in South Carolina and across the country, and therefore,

ED systems must be ready to meet the challenge through trauma-informed policies and procedures, data collection processes, and clinical practices.

First, a repeat of this study in a year's time should be done to understand how the ED improved its readiness to respond to HT. This would require the ED implementing some, if not all, of the recommendations from this study. A second study on the ED's readiness should include more sites and a larger number of ED personnel participants.

Second, research studies with other hospital systems should apply the adapted TTM framework to determine the efficacy of this assessment instrument. In addition to qualitative research, quantitative data would provide a broader awareness of where and to what extent changes are necessary within ED structures and systems as well as with other hospital system departments.

As EDs begin to implement measures to respond to HT, on-going evaluation of process changes will be necessary to ensure efficacy and to develop standards of care based on evidence. Evidence-based, trauma-informed policies and practices for EDs will increase the likelihood of HT identification and medical responses that meet patients individualized needs.

Finally, comparative research with different types of healthcare settings is necessary, using the adapted TTM framework to assess the efficacy of the model in determining HT readiness. Trafficked individuals might seek medical care at urgent care centers, primary care physician's offices, and other healthcare facilities. All healthcare settings, therefore, should be ready to respond to HT.

Implications for Policy

An effective healthcare response to HT requires a systematic approach that includes organizational policies and procedures, patient data collection processes, and clinical practices. These three systematic components interconnect in the policy driven healthcare setting. First and foremost, research demonstrates the need for healthcare settings to develop a HT protocol that addresses the three systematic components (Armstrong, Greenbaum, Lopez, & Barroso, 2019; Polaris, 2018). The HEAL Trafficking protocol toolkit for developing a trauma-informed care response to human trafficking, is a comprehensive guide for healthcare settings to improve their structure and systems (Baldwin, Barrows, & Stoklosa, 2017).

This study highlighted specific ED policies and procedures for at-risk patients that potentially intersect with HT. Healthcare settings will increase the identification of trafficked individuals with the inclusion of HT into existing policies and procedures. From a procedural standpoint, one of the recommendations from this study was to create a HT procedural flow chart that would be posted in each emergency room pod to remind clinicians of HT warning signs, documentation requirements, reporting requirements, and community resources.

As demonstrated by this study and related reports (Beck, Lineer, Melzer-Lange, Simpson, Nugent, & Rabbitt, 2015; Dovydaitis, 2010; Goldberg, Moore, Houck, Kaplan, & Barron, 2016; Hachey & Phillippi, 2017; Institute of Medicine & National Research Council, 2013; Recknor, Gemeinhardt, & Selwyn, 2018), healthcare training policies should include on-going HT trainings for healthcare professional, using different training

mechanisms to accommodate adult-learning and employee schedules. Regardless of the position with the healthcare setting, mandated training should be available to all staff since patients come into contact with a number of personnel in medical facilities. Furthermore, trainings should include a chain of command for reporting human trafficking suspicions as well as how to document suspicions and confirmations in EMRs to ensure consistency within each facility and across sites for large organizations.

Finally, healthcare settings might have policies on the use of interpretation services for non-English speaking patients. These policies might allow for interpretation services over the phone, which prohibit the interpreter from observing non-verbal and cultural cues. Therefore, as demonstrated by this study, interpretation policies should require face-to-face interpretation or virtual interpretation, when face-to-face services are unavailable. Interpreters might be able to assist clinicians in detecting possible HT situations based on non-verbal and cultural cues.

Implications for Practice

Evidenced-based, trauma-informed standards of care approaches for HT are needed for healthcare settings. Despite the lack of data, healthcare settings have standards of care to identify at-risk patients, such as sexual assault, domestic violence, and child abuse and neglect survivors, which might allow for human trafficking identification. As findings from this study showed, clinicians have ways of knowing, based on clinical experiences, if a patient seems to be at-risk. Through training efforts, healthcare settings can improve staffs' confidence to recognize trafficked individuals. In terms of practice, "the goal of a

clinical encounter is not for the patient to disclose victimization, but for providers to treat, educate, and empower the patient" (Baldwin, Barrows, & Stoklosa, 2017, p. 9).

All staff working in a healthcare setting need to be empowered to report human trafficking concerns. Since patients have contact with a range of healthcare personnel, clinical staff as well as non-clinical staff, such as administrative, security, and maintenance might have relevant information about possible trafficked individuals and should be empowered to report concerns to appropriate clinical personnel. The empowerment of all staff will help to create a responsive organizational culture.

Moreover, standards of care should include HT indicators. Several studies have identified physical, psychology, and socio-environmental factors as potential HT indicators (Fang, Coverdale, Nguyen, & Gordon, 2018; Goldberg et al., 2017; Greenbaum, 2016; Lederer & Wetzel, 2014; Shandro et al., 2016). Human trafficking indicators might be incorporated into existing screening questions for at-risk patients and other patient data collection processes. Healthcare settings also need safe places to further question at-risk patients.

APPENDICES

Appendix A

Emergent Themes, Supporting Codes, and Quotes Connected to System Processes

Emergent Theme	Supporting Code	Supporting Quote	System
Organizational awareness	*Trafficked persons seeking medical care*	*"*Knowing that Greenville is kinda the conduit between the Charlotte and Atlanta areas and, you know, having experienced concern in some patients as well, and having seen that personally, yes I do. It would not surprise me at all." "Just because of all the studies that I've heard about of the prevalence of it just in society and we see such a wide section of humanity that, you know, I know we have to be seeing these patients." "We have definitely seen some red flags, just things that are concerning that, again we haven't been trained specifically in this but I think as social workers through our studies and just through I guess our nature, we're able to see, like something is not quite right here."	CP

Appendix A (continued)

Organizational readiness cont.	*Ways of working within the organization*	"I think people are very much siloed, you know, especially with our, you know, sexual assault type patients. You know we have our SANE nurses who have that population, but even with providers I would say the majority of them are pretty uncomfortable with that kind of situation." "As far as being more comfortable with it, probably, I think a lot of people are very uncomfortable with the sexual assault, people who are being sexually trafficked, things of that nature…" "…like this group of nurses, like they have no Problems doing whatever they need to do to best serve our patients, to take care of our patients."	PP/CP
	EMR documentation	"…there's multiple ways of doing that in Epic, and so I think just, like the consistency of everyone doing these type things in the same place would be, you know, like helpful just to make sure." "I don't feel like we get consistent training on how to document things, so really it's based on whoever you observe and how they document."	PDC/CP

Appendix A (continued)

Organizational awareness cont.	*Gathering additional information*	"And it's so hard to know, like I think we have a fear of, like crying wolf so to speak, like I'm gonna call the police and, like start this whole thing and, over just, like a hunch. Or just like a, you know, it's kind of like, well should I say something, is this, are they just – and then you get busy and tied up in a million other things and it just kind of, you know, leaves your mind." "And so you feel like you don't have, like the grounds to make your argument. That's kinda how I feel, like I feel like if I'm gonna go to somebody and say, well I think this is going on, I need people to say why I think that and sometimes it's hard to put that into words I think." "…just kind of social awkwardness. Like you know, it's uncomfortable to ask a complete stranger a question like that… it's the fear of being wrong I think is the biggest, like the feel of, oh I'm gonna, like make a big stink out of this and nothing's gonna be wrong and I'm gonna look like an idiot, or I'm gonna offend this person, or you know."	PDC/CP

Appendix A (continued)

Organizational awareness cont.	*Interpretation services*	*"*We don't use the wow. It very rarely works, but usually we'll have a speaker phone and I'll have usually just on speaker." "Sometimes we get, like if they have a family member that speaks English sometimes we're kind of slack about, like talking through the family member, just for, like basic things, like I'm gonna start your IV now. But like, when the doctor comes and assesses them they always bring the interpreter."	PDC/CP
ED personnel awareness	*HT knowledge*	"With may background and training I believe that I'm more capable than others. If I was just a regular nurse, no." "I feel like I need, I feel like we all need training." "I think it's primarily just a lack of education for us."	PP/CP

Appendix A (continued)

ED personnel awareness cont.	*Handling of suspected HT cases*	"She had an older male with her that she was calling her father, but in our system reportedly she called him her uncle in the past and she was demanding that she and her son be able to stay for the night instead of being discharged but there was nothing wrong with him." "One was like a 13-year-old that basically was brought to the United States to marry this guy. And when we got everybody here involved and she was like, no I'm supposed to marry him, you can't make me leave, you can't take me away, like that's why I was brought here."	PP/PDC/CP
Ways of knowing	*Something seems off*	"It's just that feeling, like huh. Like you should know your kid's date of birth, at least the date of birth." "…if something feels, like kind of off she'll [social worker] even say, hey do you want me to go see so and so." "Also in terms of things like multiple STDs or urinary tract infections or kidney issues or things like that."	CP

Appendix A (continued)

Ways of knowing cont.	*Patient warning signs*	"You're also going to look at things such as if their partner in the room with them or someone in the room with them, how are they acting around their partner?"	CP
		"It was the controlling, the person controlling the answers."	
		"…stories change and you have kind of multiple or more frequent presentations for what we consider, like atypical type, you know, presenting several times for STDs, presenting several times for vaginal bleeding, you know, different kinda things like that would be a little bit more suspicious."	
	Handling of patients withholding information	"I try to get them alone. And then I just bluntly ask them if they're afraid or if they're being forced to do things that they don't want to."	PP/CP
		"the person that the patient has most closely identified with, who our patient feels most comfortable with, would kind of do a few more questions."	

Appendix A (continued)

Ways of knowing cont.	*Handling of patients withholding information*	"And then I go show them where the bathroom is and walk in with them so it's just me and them and say, you know, are you safe, did you really fall, so you can ask them, like in private."	
Different practice techniques	*Gathering additional information*	"Some of the things I look for is just a quick glance at the patient history, how many times they've presented to the ER and what those, not even just presenting, what those complaints are." "You know, drug and alcohol abuse, a Little bit if it's related to their presentation, but in all honesty with emergency medicine, you know, we're everyone from pregnancy to birth to I've got a 90 year old over here, and then you're trying to cover the entire array of medical knowledge and everything, so the problem is you just don't have time to, or don't take the time to dive into all those histories."	PDC/CP

Appendix A (continued)

Different practice techniques cont.	*EMR documentation*	"I feel like it's all over the place. And depending on when I find it out and where I'm at in my documentation will determine where I put it."	PDC
		"We have what we call a blue flag. You can write a note in there if you're suspicious. I don't have any problem putting it in the chart."	
		"In all honesty I have not documented in that, you know, if I have a concern that's something that I address right then. You know, I'll talk to the social worker and I'll talk to the patient, but I've never, you know, suspected human trafficking or anything like that in a chart."	
	Interpretation services	"So we'll use the iPad for ASL for, like sign language but if I'm getting an interpreter on the phone if I'm at any other hospital."	PP/CP

Appendix A (continued)

Different practice techniques cont.	*Interpretation services*	"We have in person, like Spanish interpreters but also have American Sign Language that's able to come down here. And then we have an iPad that is able to translate, oh my gosh I forget how many hundreds of languages. So, it's like a, almost like a face time versus using the blue phone that you could only speak over." "I've used a blue phone more, you know, the call service."	
Systematic improvements	*Policies and Procedures*	"But I think as, we're very policy-based here so it's like, I'm used to being told, if this happens, you do this, like in this order, this is who you report it to, this is what number you call. "So, I think it's coming up with a policy, this is how it looks for us, you know, whether it's to try to get the other person outta the room and then these are some follow up sorta style questions that you could ask." "Have a protocol. You know, we have a protocol for fires."	PP/CP

Appendix A (continued)

Systematic improvements cont.	*EMR documentation*	"…appropriate documentation, because you know, you go to these, like legal, like documentation classes and different things, and you just wanna obviously do the right thing for the patient but you also don't wanna put yourself in a situation that you have, like either like overstepped or done something, like inappropriate that could end up costing, like your license, right." "I mean, it's an absolute madhouse and you're just trying to get through, you know, pay as much attention as you have to pay to that patient so that you can move on to the next 20 that are waiting in line… we have to do a fall risk, we have to do an abuse screening, which half the time nobody asks anyway, we have to do a suicide risk assessment, we have to ask this, we have to ask that. I think, like when people are in a time crunch they're gonna cut things…" "You could have some kind of algorithm in there like that. I think that's not a bad way, it would trigger like a, we have like a, yeah there're alerts or best practice advisory sort of some sort of advisory that maybe you need to ask these follow up questions."	PDC

Appendix A (continued)

Systematic improvement cont.	*HT knowledge*	"Just a lack of knowledge. Lack of knowledge, and if this happens, what's my next step." "I think we just need more awareness of what we're looking for. You're not aware until it actually comes in here, but you, I mean, it makes you more aware when you're not here on what to look for." "I think we just need more education. On like signs to look for and, like you mentioned the tattoos, didn't have a clue about that. So now if we see that we'll know that that's a sign that we could identify."	PP/CP
	Gathering additional information	*"*Again I think one of the barriers is being able to talk with them in private." "I think we need to do more for this patient. But I feel like with trafficking it's a little bit Harder sometimes to say, well here's this… like you don't have, like the grounds to make your argument."	PDC/CP

Appendix A (continued)

Systematic improvements cont.	*Interpretation services*	"…even with the iPad the language barrier is more than just language…there are a lot of non-verbal things." "So we're very fortunate here that we actually have interpreters here 24/7. That was one of the things that was so amazing to me coming from Easley because we didn't have that there. It was like, you had to call the little hotline and it's like, you're trying to go back and forth. But here you actually have somebody who can translate for you 24/7, which is amazing."	PP/CP

*PP – policies and procedures, PDC – patient data collection, CP – clinical practice

Appendix B

Informed Consent Form
Information Concerning Participation in a Research Study
Clemson University

Improving Healthcare Readiness to Respond to Human Trafficking: A Case Study

Study to be Conducted at: *Greenville Health System's Department of Emergency Medicine*
701 Grove Road
Greenville, SC 29605

Principal Investigator: *Mark Small – 864.506.0262*
Co-Investigator: *Traci A. Hefner – 843.540.4273*

KEY INFORMATION

You are being asked to participate in a research study. Participation in a research study is voluntary. The information in this consent form is meant to better inform you so you may decide whether or not to participate in this research study. Please ask the researchers to explain anything you do not understand.

Mark Small and Traci Hefner invite you to take part in a research study, pertaining to the assessment of the Department of Emergency Medicine's (ED) readiness to respond to human trafficking (HT). Mark Small is the chair of the International Family and Community Studies Program at Clemson University. Traci Hefner is a PhD candidate in the International Family and Community Studies Program who will run this study under the guidance of Dr. Small. The purpose of this case study is to assess and improve the readiness of the Department of Emergency Medicine to identify, assess, and respond to human trafficking. The study's research objectives are to: 1) provide an organizing framework to understand the ED's readiness to respond to HT, using the Transtheoretical Model's (TTM) stages of change construct, 2) explain the readiness of the ED through a three-pronged contextual approach that included policies and procedures, patient data collection processes, and clinical practice methods, and 3) develop recommendations to respond to HT.

The ED's participation in the study will include: 1) providing policies and procedures for vulnerable populations for review, 2) assisting with aggregated patient data reports on vulnerable populations, and 3) allowing for site observations and interviews with a broad range of ED staff, including physicians, nurses, and social workers. Each facility will receive a minimum of two site observations. The observations will be for three hours, totaling 6 hours at each site. Interviews will be conducted with ED staff on-site at a convenient date and time for each participant. The

interviews will be no more than 45 minutes in length and will include approximately 30 to 40 ED staff.

The Institutional Review Board of the Greenville Health System has reviewed this study for the protection of the rights of human participants in research studies, in accordance with federal and state regulations.

The study is being conducted as part of the dissertation requirements of Clemson University's International Family and Children's Studies Program.

PURPOSE

The aim of this study is to improve Greenville Health System (GHS) Department of Emergency Medicine's (ED) readiness to identify, assess, and respond to trafficked individuals. Specifically, the research objectives are to: 1) provide an organizing framework to understand the readiness of the ED's systems to respond to human trafficking, using the Transtheoretical Model's (TTM) stages of change construct, 2) explain the readiness of the ED's policies and procedures, patient data collection processes, and clinical practice methods, and 3) develop recommendations to enhance the ED's readiness to respond to human trafficking.

HOW THE STUDY WORKS

The research will begin in November 2018 and may go to May 2019. Participation time for each site location will range from 8 to 18 hours, depending on the type of facility (emergency rooms/urgent care centers).

POSSIBLE RISKS

There are no known medical risks related to participation in this study. This study may result in presentations and publications, but steps will be taken to protect privacy and confidentiality. Reports of study findings will not include any identifying information. All documentation, such as field notes, will be given codes and stored in a locked file cabinet in the Institute on Family and Neighborhood Life at Clemson University. Electronic documentation, such as interview audio recordings and audio transcripts, will be maintained on a password-protected computer. Only research personnel associated with this study will have access to the data.

Specific to interviews, participants will be asked whether the interview may be audio recorded. Their preference will be honored. After the interview recording is transcribed, the audio recording will be destroyed.

We might be required to share the information we collected from the organization with the Clemson University Office of Research Compliance and the federal Office for Human Research Protection.

If this happens, the information would only be used to find out if we ran this study properly and protected the rights of staff in the study.

POSSIBLE BENEFITS

We do not know of any direct individual benefits that may be attributed to participating in this study. However, this research will help to provide a better response to patients at-risk of human trafficking by informing the ED about the readiness of its systems. Your input also will assist in providing recommendations for improving the ED's policies and procedures, data collection processes, and clinical practices for the identification and treatment of trafficked individuals.

ALTERNATIVES

The decision to participate in this study is entirely up to you. The alternative to participating in this study is simply not to participate. If you decide not to participate in the study, you will not be penalized in any way.

PAYMENT FOR PARTICIPATION

You will not be paid for participating in this study.

To Investigators:

The investigators will not be paid for conducting this study.

VOLUNTARY PARTICIPATION

Participation in this research study is voluntary. You may refuse to participate or withdraw from the study at any time. If you refuse to participate or withdraw from the study, you will not be penalized or lose any benefits and your decision will not affect your relationship with Department of Emergency Medicine.

If the organization chooses to stop taking part in this study, the information already provided will be used in a confidential manner.

CONFIDENTIALITY

We will do everything we can to protect privacy and confidentiality. This research, along with possible reports or publications, will not include any individual identities. All documentation, including demographic questionnaires from focus group meetings will be given codes and stored in

a locked file at all times. Electronic documentation as well as interview audios and transcripts will be maintained in a secure computer file. Only research personnel will have access to the data.

Specific to interviews, participants will be asked whether the interview may be audio recorded. Their preference will be honored. Only the name of the site and job category (physician, nurse, social worker) will appear in the final report.

CONTACT FOR QUESTIONS

For more information concerning this study and research-related risks or injuries, or to give comments or express concerns or complaints, you may contact the study coordinator, Traci Hefner at 843.540.4273.

You may also contact a representative of the Institutional Review Board of the Greenville Health System for information regarding your rights as a participant involved in a research study or to give comments or express concerns, complaints or offer input. You may obtain the name and number of this person by calling (864) 455-8997.

A survey about your experience with this informed consent process is located at the following website:

https://www.surveymonkey.com/s/T5C86P8

Participation in the survey is completely anonymous and voluntary and will not affect your relationship with the Greenville Health System. If you would like to have a paper copy of this survey, please tell your study researcher.

CONSENT TO PARTICIPATE

The research investigator, _____, has explained the nature and purpose of this study to me. I have been given the time and place to read and review this consent form and I choose to participate in this study. I have been given the opportunity to ask questions about this study and my questions have been answered to my satisfaction. After I sign this consent form, I will receive a copy of it for my own records. I do not give up any of my legal rights by signing this consent form.

_____

Printed Name of Participant

_____ _____ _____

Signature of Participant Date Time

INVESTIGATOR STATEMENT

I have carefully explained to the participant the nature and purpose of the above study. The participant signing this consent form has (1) been given the time and place to read and review this consent form; (2) been given an opportunity to ask questions regarding the nature, risks and benefits of participation in this research study; and (3) appears to understand the nature and purpose of the study and the demands required of participation. The participant has signed this consent form prior to having any study-related procedures performed.

_____	_____	_____
Signature of Co-Investigator	Date	Time

Informed Consent Form for Healthcare Provider Interviews
Information Concerning Participation in a Research Study
Clemson University

Improving Healthcare Readiness to Respond to Human Trafficking: A Case Study

Study to be Conducted at: *Greenville Health System's Department of Emergency Medicine*
701 Grove Road
Greenville, SC 29605

Principal Investigator: *Mark Small – 864.506.0262*
Co-Investigator: *Traci A. Hefner – 843.540.4273*

KEY INFORMATION

You are being asked to participate in a research study. Participation in a research study is voluntary. The information in this consent form is meant to better inform you so you may decide whether or not to participate in this research study. Please ask the researchers to explain anything you do not understand.

Mark Small and Traci Hefner invite you to take part in a research study, pertaining to the assessment of the Department of Emergency Medicine's (ED) readiness to respond to human trafficking (HT). Mark Small is the chair of the International Family and Community Studies Program at Clemson University. Traci Hefner is a PhD candidate in the International Family and Community Studies Program who will run this study under the guidance of Dr. Small. The purpose of this case study is to improve the readiness of the Department of Emergency Medicine to identify, assess, and respond to human trafficking. The study's research objectives are to: 1) provide an organizing framework to understand the ED's readiness to respond to HT, using the Transtheoretical Model's (TTM) stages of change construct, 2) explain the readiness of the ED through a three-pronged contextual approach that included policies and procedures, patient data collection processes, and clinical practice methods, and 3) develop recommendations to respond to HT.

Your participation in the study will include: 1) providing feedback on integrating human trafficking into current ED policies and procedures for vulnerable populations, data collection process, and clinical practice methods, and 2) helping to identify potential barriers and challenges to integrating human trafficking into the ED's systems.

The Institutional Review Board of the Greenville Health System has reviewed this study for the protection of the rights of human participants in research studies, in accordance with federal and state regulations.

The study is being conducted as part of the dissertation requirements of Clemson University's International Family and Community Studies Program.

PURPOSE

The aim of this study is to improve Greenville Health System (GHS) Department of Emergency Medicine's (ED) readiness to identify, assess, and respond to trafficked individuals. Specifically, the research objectives are to: 1) provide an organizing framework to understand the readiness of the ED's systems to respond to human trafficking, using the Transtheoretical Model's (TTM) stages of change construct, 2) explain the readiness of the ED's policies and procedures, patient data collection processes, and clinical practice methods, and 3) develop recommendations to enhance the ED's readiness to respond to human trafficking.

HOW THE STUDY WORKS

The research will begin in January 2019 and may go to May 2019. Your interview is scheduled for _____ (location) on _____ at _____. The interview will take 30 minutes or less.

POSSIBLE RISKS

There are no known medical risks related to participation in this study. This study may result in presentations and publications, but steps will be taken to protect privacy and confidentiality. Reports of study findings will not include any identifying information. All documentation, including field notes and demographic questionnaires from interviews, will be given codes and stored in a locked file cabinet in the Institute on Family and Neighborhood Life at Clemson University. Electronic documentation, such as interview audio recordings and audio transcripts, will be maintained on a password-protected computer. Only research personnel associated with this study will have access to the data.

Participants will be asked whether the interview may be audio recorded. Their preference will be honored. After the interview recording is transcribed, the audio recording will be destroyed.

We might be required to share the information we collected from the organization with the Clemson University Office of Research Compliance and the federal Office for Human Research Protection. If this happens, the information would only be used to find out if we ran this study properly and protected the rights of staff in the study.

POSSIBLE BENEFITS

We do not know of any way you would benefit directly from taking part in this study. However, this research will help to provide a better response to patients at-risk of human trafficking by informing the ED about the readiness of its systems. Your input also will assist in providing recommendations for improving the ED's policies and procedures, data collection processes, and clinical practices for the identification, assessment, and treatment of trafficked individuals.

ALTERNATIVES

The decision to participate in this study is entirely up to you. The alternative to participating in this study is simply not to participate. If you decide not to participate in the study, you will not be penalized in any way.

PAYMENT FOR PARTICIPATION

You will not be paid for participating in this study.

To Investigators:

The investigators will not be paid for conducting this study.

VOLUNTARY PARTICIPATION

Participation in this research study is voluntary. You may refuse to participate or withdraw from the study at any time. If you refuse to participate or withdraw from the study, you will not be penalized or lose any benefits and your decision will not affect your relationship with Department of Emergency Medicine.

If you choose to stop taking part in this study, the information already provided will be used in a confidential manner.

CONFIDENTIALITY

We will do everything we can to protect privacy and confidentiality. This researcher will not include any individual identities.

Audio recordings and transcriptions of interviews will be kept on a password protected computer. After the interview recording is transcribed, the audio recording will be destroyed. Interview notes will be stored in a locked filing cabinet in the Institute on Family and Neighborhood Life at Clemson University. Only research personnel associated with this study will have access to the data.

CONTACT FOR QUESTIONS

For more information concerning this study and research-related risks or injuries, or to give comments or express concerns or complaints, you may contact the study coordinator, Traci Hefner at 843.540.4273.

You may also contact a representative of the Institutional Review Board of the Greenville Health System for information regarding your rights as a participant involved in a research study or to give comments or express concerns, complaints or offer input. You may obtain the name and number of this person by calling (864) 455-8997.

A survey about your experience with this informed consent process is located at the following website:

https://www.surveymonkey.com/s/T5C86P8

Participation in the survey is completely anonymous and voluntary and will not affect your relationship with the Greenville Health System. If you would like to have a paper copy of this survey, please tell your study researcher.

AUDIO RECORDING of INTERVIEWS

Audio recording devices will be used unless you specify otherwise. The purpose is to assist the researcher in confirming responses and information in preparing a final report. Upon completion of the interview, the audio recording will be downloaded to a secure computer file.

Please initial below if you are willing to have your responses audio recorded. If you do not agree to have your responses audio recorded, the researcher will pause the recording devise when you speak.

_____ I agree to allow my responses to be audio recorded.

_____ I do not agree to have my responses audio recorded.

CONSENT TO PARTICIPATE

The research investigator, _____**Traci Hefner**_____, has explained the nature and purpose of this study to me. I have been given the time and place to read and review this consent form and I choose to participate in this study. I have been given the opportunity to ask questions about this study and my questions have been answered to my satisfaction. After I sign this consent form, I will receive a copy of it for my own records. I do not give up any of my legal rights by signing this consent form.

_____

Printed Name of Participant

_____ _____ _____

Signature of Participant Date Time

INVESTIGATOR STATEMENT

I have carefully explained to the participant the nature and purpose of the above study. The participant signing this consent form has (1) been given the time and place to read and review this consent form; (2) been given an opportunity to ask questions regarding the nature, risks and benefits of participation in this research study; and (3) appears to understand the nature and purpose of the study and the demands required of participation. The participant has signed this consent form prior to having any study-related procedures performed.

_____ _____ _____

Signature of Co-Investigator Date Time

Appendix C

Policies and Procedures Review

Policy & Procedure	Patient Population	Oversight Responsibilities	Staff Responsibilities	Documentation Requirements	Reporting & Timeline Requirements

Notes:

Appendix D

Human Trafficking Indicator Checklist

Human Trafficking Indictor	Data Collected	Collected When in Process	Adult Patients	Child Patients
Medical History				
Mental health disorder	No Yes			
Health visit within last 2 months	No Yes			
History of CSEC or ASA	No Yes			
Current Anogenital Symptoms				
Vaginal discharge	No Yes			
Genital pain	No Yes			
Itching	No Yes			
Abnormal bleeding	No Yes			
Pelvic pain	No Yes			
Rectal pain	No Yes			
Sexual History				
How long sexually active	No Yes			
History of STI	No Yes			
Pregnancy	No Yes			
Birth control use	No Yes			
Menstrual problems	No Yes			
Other Histories				
History of violence with caregiver	No Yes			
History of fractures, LOC, wounds	No Yes			

History of violence	No Yes			
History of drug use	No Yes			
History of multiple drug use	No Yes			
History of running away	No Yes			
CPS history	No Yes			
History with police	No Yes			
Other				
Tattoos	No Yes			

Appendix E

Site Observation Safety Question Checklist

Date: **Times:**

Site:

Setting:

Staff Job Category: **Gender of Staff:**

Patient ID	**Gender**	**Safety Question**	**Question Asked**	**Question asked with patient only**	**Observation of patient**	**Follow up questions**
01	Female Male Other	Do you feel safe in your home?	Yes No	Yes No	Yes No	Yes No
		Do you feel safe in your relationship?	Yes No	Yes No	Yes No	Yes No
Field Notes:						
02	Female Male Other	Do you feel safe in your home?	Yes No	Yes No	Yes No	Yes No
		Do you feel safe in your relationship?	Yes No	Yes No	Yes No	Yes No
Field Notes:						

Appendix F

Interview Protocol for Healthcare Providers

ID#: _____ **GHS Site: _____**

Date: _____ **Time: _____**

Demographic Information:

1. What is your gender?

2. What is your race?

3. What is your current position/department?

4. How long have you worked in your current position?

5. What is your highest level of education?

6. Do you have a professional license? If so, what license do you have?

7. Have you received training on human trafficking within the past two years?
   Yes, where? _____ No

   a. If yes, was your training for your professional license?
      Yes No

   b. If yes, did your training focus on labor trafficking, sex trafficking, or both?

Questions

8. Do you believe that trafficked individuals are seeking medical care in your facility? If yes, what warning signs did you recognize? How did you handle the situation?

9. Do you believe that you currently have the knowledge to identify, assess, and respond to trafficked persons? If yes, where did you obtain the information on warning signs? If no, would you be interested in a trauma-informed response to human trafficking training? How would you like the training delivered?

10. As ED staff, you work with various categories of vulnerable patient populations. Do ED staff tend to work across organizational boundaries or in silos? Explain.

11. When asking safety questions, what type of non-verbal warning signs do you look for in a patient?

12. How do you address safety questions with a patient when there is a language barrier?

13. If you feel that a patient is withholding information about his or her safety, what do you do? Can you give examples?

14. If you have concerns about a patient's history of violence, running away, drug and alcohol use, and sexual activity, how do attempt to gather additional information?

15. Who is responsible for making community referrals for vulnerable patients? How are referrals documented?

16. What steps would you recommend that the ED take to improve its policies/procedures, data collection processes, and clinical practices to respond to human trafficking?

17. What do you perceive as the current barriers to identifying and treating potential trafficked persons seeking medical care in the ED?

Appendix G

Transcriber's Confidentiality Agreement

Improving Healthcare Readiness to Respond to Human Trafficking: A Case Study

Transcriptionist's Confidentiality Agreement

I, _____, will be transcribing Traci Hefner's interview recordings for her Improving Healthcare Readiness to Respond to Human Trafficking study.

I promise to hold all interview information confidential and maintain participants' anonymity. I will not discuss the content of the interviews with any persons. To do so would be a serious ethical breach.

_____ _____

Signature of Transcriptionist Date

_____ _____

Signature of Co-Investigator Date

Appendix H

Screening Questions

1. Can you leave your job or situation if you want?
2. Can you come and go as you please?
3. Have you been threatened if you try to leave?
4. Have you been physically harmed in any way?
5. What are our working or living conditions like?
6. Where do you sleep and eat?
7. Do you sleep in a bed, on a cot, or on the floor?
8. Have you ever been deprived of food, water, sleep, or medical care?
9. Do you have to ask permission to eat, sleep, or go to the bathroom?
10. Are there locks on your doors and windows so you cannot get out?
11. Has anyone threatened your family?
12. Has your identification or documentation been taken from you?
13. Is anyone forcing you to do anything that you do not want to do?

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