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Identification of Victims of Human Trafficking: Leading Change through a Global Pandemic

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List of Acronyms and Abbreviations

AHA	American Hospital Association
AHS	Asian Health Services
ANA	American Nurses Association
AONL	Association of Nursing Leadership
ATO	anti-trafficking organization
CAST	Coalition to Abolish Slavery and Trafficking
CBA	cost/benefit analysis
CDC	Centers for Disease Control and Prevention
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CITI	Collaborative Institutional Training Initiative
CBR	Cost-benefit ratio
CoV-1	coronavirus – 1
CoV-2	coronavirus – 2
COVID-19	coronavirus disease 2019
CSEC	commercially sexually exploited children
CST	child sex trafficking
DMST	domestic minor sex trafficked youth
CAPC	child and adolescent protection center
DNP	Doctor of Nursing Practice
ED	emergency department
EHR	electronic health record
ETO	efforts to outcomes
HCP	health care provider
HT	human trafficking
HTR	human trafficking response
HTST	human trafficking screening tool
ILO	International Labour Organization
IRB	Institutional review board
IT	Information technology
KPI	Key performance indicators
L&D	labor and delivery
LMS	learning management system
NCMEC	National Center for Missing and Exploited Children
NGO	non-governmental organization
NHTH	national human trafficking hotline
NSN	National Survivor Network
OVC	Office for Victims of Crime
PCP	primary care provider
PEARR	provide privacy, educate, ask, respect, and respond
PI	principal investigator
PPE	personal protective equipment
QYIT	Quick Youth Indicators for Trafficking

RN	Registered Nurse
RNA	ribonucleic acid
SAMSA	Substance Abuse and Mental Health Services Administration
SARS	Severe acute respiratory syndrome
SME	subject matter expert
STI	sexually transmitted infection
SWOT	strengths, weaknesses, opportunities, and threats
TVIT	Trafficking Victim Identification Tool
TVPA	Trafficking Victims Protection Act
TVPRA	Trafficking Victims Protection Reauthorization Act
U.S. DoJ	United States Department of Justice
U.S. GPO	United States Government Publishing Office
USF	University of San Francisco
VAWRA	Violence Against Women Reauthorization Act
WBS	work breakdown structure
WHO	World Health Organization

**Identification of Victims of Human Trafficking:
Leading Change through a Global Pandemic**

Section 1: Executive Summary

Human trafficking is a multi-billion-dollar global industry, generating \$150 billion annually (International Labour Organization [ILO], 2014), and driven by the exploitation of victims of all ages, primarily for forced labor or commercial sex. Victims endure frequent and prolonged abuse, suffering illnesses, and injuries. When accessing the health care system, they often go unrecognized by health care providers and nurses. Recognition requires training to raise awareness and the right tools to capture the information necessary to identify victims and address opportunities to improve their safety, care, and support. The aim of this Doctor of Nursing Practice (DNP) evidence-based change project was to improve the recognition and identification of victims of human trafficking by emergency department and labor and delivery clinicians through (1) participation in a standardized training program built on the provision of victim-centered, trauma-informed care, and (2) the creation and use of a screening tool template in the electronic health record (EHR). An important secondary goal included increasing the number of referrals made for community services on the identified victims' behalf.

CommonSpirit Health was created as a single ministry in February 2019, formed by the alignment of two legacies of caring, Dignity Health and Catholic Health Initiatives. Dignity Health facilities participated in this project, and there are plans to expand to the entire CommonSpirit Health system in future phases. Unexpectedly, the global pandemic disrupted the project plan and timelines, prompting a re-evaluation of the project and the need to create contingency and collateral workstreams. Activities were re-prioritized, and the Phase II initiative became the Phase I interventions.

Three-module training programs for clinical staff were developed: (1) Human trafficking 101: Dispelling the myths, (2) Trauma-informed patient care and services, and (3) PEARR: Five steps to victim assistance in health care settings. Each module included comprehension questions, and a score of 80% was required to complete each learning module successfully. Due to a moratorium on non-essential training during the height of the pandemic, these modules were not assigned to clinicians for completion until September 1, 2020. Clinicians in the emergency departments (ED) of three Dignity Health acute care facilities in southern California were assigned the modules and given 30 days to complete them. Comprehension improved from 87.1% (n=307) at baseline to 91.5% (n=302) for those modules completed by September 30, 2020; the 5.05% improvement ($p=.6018$; 95% CI) was not statistically significant. It may be clinically significant because these clinicians now have greater knowledge and awareness to recognize victims of human trafficking who present to the ED and then take action to offer services.

The benefit-cost ratio for the learning modules was 2.47 based on estimates of the “soft” benefits or intangible benefits to victims and society, indicating this project was feasible and beneficial to the organization. However, to fully measure the benefit-cost ratio of the DNP project, data are needed to determine if clinicians who receive standardized training can better identify victims of human trafficking. Data collection and analyses will be extended beyond the timeframe of this project and compared to the baseline. Additionally, the project plan for creating and implementing the standard screening tool in the EHR was modified to relaunch in the mid-calendar year 2021, pending the status of the COVID-19 pandemic.

In summary, human trafficking is a public health crisis and one of the most lucrative crimes in the world (ILO, 2017). Standardized tools and training are needed to aid clinicians in

screening and identifying victims. The executive nurse leader can effectively lead change during a global pandemic by using change management theory, nursing theory, demonstration of leadership competencies, and a strong understanding of project management principles. In doing so, care delivery can be improved, even for those most vulnerable and hiding in the shadows.

Keywords: labor trafficking, sexual exploitation, child sex trafficking, forced labor, violence, abuse, screening, identification, red flags

**Identification of Victims of Human Trafficking:
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Section II: Introduction

Human Trafficking: The Problem

Human trafficking (HT), as defined by the United States Department of Justice ([U.S DoJ], n.d.), is the exploitation of a person through “force, fraud or coercion” to perform commercial sex acts, labor, or services. The scope and magnitude of this attack on human rights and human dignity are challenging to measure as the victims of commercial sex and forced labor trafficking often go unrecognized. Occurring in every country and every state in the United States (United Nations, n.d.), victims are traded or sold like property without their consent; their freedoms are taken away for the financial gain of another. Unlike human smuggling that requires the movement or transportation of victims across state or national borders, human trafficking centers on illegal exploitation. It can occur in the victim’s hometown or even in their home.

The context globally.

Over 40 million people worldwide (5.4 per 1000 people) are forced into exploitation; they cannot leave or refuse to participate because of threats, coercion, force, fraud, or abuse of power. According to the International Labour Organization [ILO] (2017), women and girls account for 71% of all human trafficking victims, with women and children comprising 99% of the forced sex trade (of which children make up 21% of all victims). The exact number of HT victims is unknown as these types of crimes go un- or under-reported by victims reluctant to or too young to self-report. Safe harbor laws are designed to provide access to medical care, social

services support, safe housing (Weiss, 2015), and criminalization protection. Yet, victims are reluctant to report their exploitation out of shame or fear of criminal prosecution.

Most victims are targeted due to their vulnerabilities, and children as young as infants are at risk for sexual exploitation, the number one form of human trafficking. A recent report published by the National Center for Missing and Exploited Children (NCMEC, 2019) indicated that one in seven endangered runaway children are likely victims of child commercial sex exploitation; the average age of these victims is approximately 15 years old. Sadly, child sex trafficking occurs in all 50 states. Children under the age of 18 who perform commercial sex acts (e.g., pornography) are considered sex trafficking victims without exception (NCMEC, 2019).

The context nationally.

The United States ranks among the worst countries globally for human trafficking (HT), with California identified as the top state for HT cases reported in 2018. For victims whose citizenship was known, 54.8% are US citizens, and 45.2% are foreign nationals (National Human Trafficking Hotline, (NHTH) 2019). Polaris, a national leader in anti-trafficking, reported 51,9191 calls received by their Human Trafficking Hotline since its inception in 2007. In 2018, the Hotline received 10,9494 calls, with 72.3% representing sex trafficking cases, 11.4% labor trafficking, 5.8% both sex and labor trafficking, and approximately 11% were unspecified (Polaris, 2019).

Surprisingly, human trafficking was not illegal in the United States until the year 2000, when the Trafficking Victims Protection Act (TVPA) was passed and became a federal law (United States Government Publishing Office [USGPO], 2000). The TVPA was reauthorized in 2003 and signed into law as the Trafficking Victims Protection Reauthorization Act (TVPRA).

The TVPRA includes a federal civil rights action that allows victims to sue their traffickers (Trafficking Victims Protection Reauthorization Act [TVPRA], 2003). Reauthorization in 2005 created grant programs to assist states and law enforcement in combating human trafficking, in fighting sex tourism, and it launched a pilot program to shelter survivors who are minors (TVPRA, 2006). The William Wilberforce Trafficking Victims Protection Reauthorization Act (TVPRA) of 2008 focused on prevention strategies, data collection and reporting, expanded sanctions against traffickers, and definitions of various forms of trafficking to improve prosecution efforts (TVPRA, 2008). The TVPRA (2013) was reauthorized as an amendment to the Violence Against Women Reauthorization Act (VAWRA) of 2013 (VAWRA, 2013), focusing on the prevention of child marriages and purchases of products made by victims of forced labor.

The context related to Dignity Health.

Dignity Health, a not-for-profit public benefit corporation, operates over 400 care sites that include 41 acute care hospitals in three states: Arizona, California, and Nevada (Dignity Health, n.d.) (see Appendix A); of which two-thirds are faith-based and rooted in the Catholic tradition. As the fifth-largest health system in the country and the largest provider in California, Dignity Health values Collaboration, Excellence, Stewardship, Dignity, and Justice. Of these five values, Justice is the foundation for the work efforts to be a leader in combating human trafficking. Justice is about advocacy for social change and respecting all persons, especially those who are poor, powerless, and disenfranchised (Dignity Health, 2014). Rooted in the teachings of the founding congregations and women religious, and built upon the value of Justice, Dignity Health launched a Human Trafficking Response (HTR) program in 2014.

Due to its global prevalence and the adverse health consequences of abuse, violence, and exploitation, human trafficking must be treated as a public health emergency. Dignity Health, and now CommonSpirit Health, are recognized health care leaders fighting against human trafficking through their advocacy efforts and by creating and openly sharing resource materials to serve as a benchmark for other health systems (CommonSpirit, 2019b). Dignity Health's commitment to caring for the vulnerable, and the significance of human trafficking in the communities it serves, underscores the commitment to improve the recognition and identification of patients at risk for exploitation.

The setting.

In the past three years (2017-2019), Dignity Health has invested over \$1.5 million in training over 20,000 staff, physicians, and volunteers to recognize trafficking victims and provide trauma-informed care. Online resources and training materials are made available at no cost on the Dignity Health website (Dignity Health, 2019a). To date, over 400 professionals from other hospitals and health systems are trained. Despite efforts to raise awareness, both internally and externally, recognition of human trafficking victims currently depends on human factors and individual clinicians' ability to ask the right questions, look for subtle cues, and assimilate assessment findings and subjective data to "connect the dots."

Significance.

In 2019, the National Human Trafficking Hotline (2019) reported 11,500 cases of human trafficking, with California ranked first (n = 1,507), Nevada ranked thirteenth (n = 239), and Arizona ranked fourteenth (n = 234) among the top 20 states reporting cases. However, due to the stealth and covert nature of trafficking another human being, statistics about the prevalence and incidence are not exact. Based on available information from 2016, 5.4 in 1000 people and

one in four children worldwide are victims of trafficking in some form, the majority in commercial sex trafficking (ILO, 2017). In 2018, Dignity Health provided care to over two million patients through their emergency departments and almost 60,000 patients through their labor and delivery units (Dignity Health, 2018). Applying the ILO (2017) statistics to these populations, it is conceivable that Dignity Health cared for over 14,000 unrecognized victims of sexual or forced labor exploitation in their EDs and obstetrical units (10,800 patients and 324 patients, respectively). Sadly, similar statistics could be found at hospitals and clinics across this country.

Health care services are some of the most accessed services by trafficking victims, and health care workers must assist them. Identification and rescue are impossible without recognizing the possibility of exploitation, assessing indications to identify the high-risk potential, and making appropriate connections and referrals. The American Nurses Association (2016) issued a position statement describing the nurse's role in protecting and promoting human rights in practice settings and supporting Provision 1 of the Code of Ethics (Fowler, 2015) as a fundamental professional nursing principle.

Several factors contribute to the failure of health care providers and clinicians to identify victims and survivors, including (a) misconceptions, personal bias, and stereotypes, (b) overall lack of understanding, training, and awareness, (c) lack of policies and protocols, (d) mandated reporting requirements, and (e) reluctance on the part of the victim to self-disclose (National Research Council [NRC], 2014). Identification is the first step in a trauma-informed approach to caring for victims of violence and trafficking (Center for Substance Abuse Treatment [CSAT], 2014; Menschner & Maul, 2016). In a study published by Beck et al. (2015), 63% of health care workers reported they have never received training on ways to identify HT victims. Confidence

in their ability to identify ($p < .001$) and likelihood to report sex trafficking ($p \leq .001$) was significant for those who received training. Training increased awareness of human trafficking and healthcare providers' roles, but education alone is not enough. Nurse leaders must provide tools to facilitate patient safety, patient-centered and trauma-informed care and timeliness, and access to care and services.

Despite the progress made by law enforcement, the criminal justice system, and through international efforts and collaboration, human trafficking victims are often difficult to recognize. A failure to recognize is a missed opportunity to protect, intervene, and offer needed services and support.

PICOT Question

Dignity Health launched its Human Trafficking Response Program in 2014 and has gained national recognition as a leader in addressing this vulnerable population through its victim-led, trauma-informed education, training program, and resources. Using the Fineout-Overholt (2006) PICOT question template (as cited in Melnyk, Gallagher-Ford & Fineout-Overholt, 2017), the PICOT question for this project was:

For trafficked persons who present to a Dignity Health acute care facility for care, (P) does the use of a standardized assessment and documentation tool template embedded in the electronic health record (EHR) (I) compared to current state practices (C) improve identification of persons at high risk for sex or labor trafficking (O) within 90 days of implementation of the tool?

Available Knowledge

Literature search.

The PICOT clinical question was defined and served to inform the literature search strategy; key concepts and terms determined the most appropriate methodologies and the type of

evidence to aid in answering the clinical question (see Appendix B). Using the following six electronic databases: Google Scholar, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) Complete, PubMed, SCOPUS, COCHRANE, and Joanna Briggs, a literature search was conducted using the terms “human traffick*,” “sex traffick*,” “labor traffick*,” “sign*,” “identif*,” and “screen*” (see Appendix B). A search filter was applied to limit the articles to the English language only and years of publication (2000-2019). Refining the search required the removal of duplicate studies and limiting them to peer-reviewed journals. This phase of the investigation resulted in 68 articles. Following a title and abstract review and screening, 52 articles were retrieved for full article review. Twenty articles were excluded following full article review, and an additional 12 studies were excluded because they applied to law enforcement or the criminal justice system. A literature review was conducted to identify a preponderance of the evidence available to describe the clinical questions and support the proposed intervention. Twenty articles were selected for a full review, appraisal, and an evidence table was completed (see Appendix C). The level and quality of evidence ranged from Level II-A to Level V-C, with most of the articles appraised at Level III-B.

Literature Review.

Several studies (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Becker & Bechtel, 2015; Dovydaitis, 2010; Lederer & Wetzels, 2014;) demonstrated that as little as 28% and as many as 87.8% of victims accessed the health care system during the time of their exploitation. In some cases, none were identified as victims. A lack of a standardized approach or standardized tool contributes to this low recognition rate.

Human trafficking screening tools currently exist, yet not all are validated, or if validated, not in the health care environment (Polaris, 2011). Studies have identified variations in the

number of questions, content, time, and level of expertise required to administer the screening tool (Armstrong, 2017; Bernalova, Morgan, & Coverdale, 2016; Chisolm-Straker, Sze, Einbond, White, & Stoklosa, 2019; Greenbaum et al., 2018; Mumma et al., 2017; Simich, Goyen, Powell, & Mallozzi, 2014; Williams, Wyatt & Gaddis, 2018). The questionnaires contain between three to 100 questions, can take up to one hour to complete the screening, and be administered by a human trafficking expert. These constraints do not make it feasible or desirable for use in departments like the Emergency Department or Labor and Delivery Unit, where time constraints require rapid assessments and decision-making.

Chisolm-Straker et al. (2019) developed an abbreviated screening tool for homeless young adults derived from Vera Institute Human Trafficking Victim Identification Tool (VERA Institute of Justice, 2014; Simich et al., 2014) called the Quick Youth Indicators for Trafficking (QYIT) tool. The QYIT tool had a sensitivity of 86.7% and 76.5% specificity when at least one question is answered with a “yes.” Although highly sensitive and easy to use, the findings are not generalizable to other age groups, settings, or demographics.

Greenbaum, Dodd, and McCracken (2016) created a screening tool to identify potential sex trafficking victims among high-risk adolescents. Their tool included assessments of high-risk behaviors, medical and reproductive history, mental health issues, substance abuse, and history of violence and injury. Data collection included medical records reviews and observations for signs of intoxication, overall demeanor, and chief complaint. Like the tool developed by Chisolm-Straker et al. (2019), this child sex trafficking (CST) screening tool had a high sensitivity (92%), a positive predictive value of 51%, and a negative predictive value of 97%. Neither tool definitively identifies a victim of human trafficking, although each tool's high negative predictive value makes them useful in identifying non-trafficked patients. Similar

results were found by Greenbaum et al., 2018; Kaltiso et al., 2018; and Mumma et al., 2017. The literature suggests that questions about living situations and work environments may offer clues to trafficking (Chisolm-Straker et al., 2016; Dank et al., 2017; Goldberg, Moore, Houck, Kaplan & Barron, 2017; Greenbaum et al., 2016; Mumma et al., 2017). Despite an increase in research in the past ten years related to human trafficking, there is no validated tool designed for health care that can confirm a victim of human trafficking that exists today.

Other factors can be indicators of commercial sex or forced labor trafficking, or a combination of both. Several studies have published individual risk factors, especially among youth and adolescents, that shed light on their vulnerability to trafficking, such as limited social support systems, coping skills, and life experiences (Briere & Simon, 2014; Goldberg et al., 2017; Smith, Vardaman & Snow, 2009). Through retrospective medical record review, structured interviews, observations, and surveys, several patterns of health issues are becoming evident. Females are statistically more likely to be victims of sex trafficking (Chisolm-Straker et al., 2019; Mostajabian, Santa Maria, Wiemann, Newling, and Bocchini, 2019; Simich et al., 2014). Sadly, female children with two or more risk factors, a history of sexually transmitted infections, or multiple sexual partners are (six times, 15 times, and up to 19 times respectively) more likely to have experienced sexual exploitation (Chang, Lee, Park & Quach, 2015).

Many chief complaints and physical signs identified in these patients are related to events preceding the trafficking or resulting from the violence and abuse of being exploited. Sexual abuse, drug and substance abuse, trauma or history of violence, and mental health issues were prevalent among the identified victims (Ertl et al., 2019; Goldberg et al., 2017; Greenbaum et al., 2016; Kaltiso et al., 2018; Lederer & Wetzell, 2014; Varma, Gillespie, McCracken, & Greenbaum, 2015).

Even when victims accessed the healthcare system with these and other signs of abuse, they often went unrecognized as human trafficking victims. Dols, Beckmann-Mendez, McDow, Walker, and Moon (2019) found that only 40.7% of EDs along the Mexican border in south Texas screened for human trafficking among adult patients. No patients were identified as victims. Similarly, Armstrong, Greenbaum, López, and Barroso (2019) found that 72.8% of ED leaders surveyed believed human trafficking occurred in their area, yet 77.8% reported they had not cared for an HT victim. Despite feeling “that something was not right,” these nurses could not move from suspicion to identification.

Baldwin et al. (2011) found that 50% of their sample had visited a health care provider (HCP) while under the control of their trafficker, which often stifled communication and interaction between the victim and the HCP. None of the patients in this study were identified correctly despite interviews conducted in person and in a private room. Chisolm-Straker et al. (2016) found through surveys that 73% of survivors wanted to access the health care system and be seen by an HCP, but only 68% were seen; of those seen by an HCP, 56% were seen by an emergency or urgent care provider and 44.4% by a primary care provider. Physical abuse was reported as the most common reason for seeking care (66%). Of those victims identified by an HCP, 90% were questioned about their work and their living situation; when their victimization was confirmed, only 56% had an intervention performed that could lead to rescue.

Given the scarcity of high-quality evidence to validate the signs and indicators of human trafficking, this project's need is evident. Awareness alone is not enough (Dols et al., 2019; Ertl et al., 2019). Victims of commercial sexual and forced labor exploitation are fearful and often controlled by their traffickers. The solution to improving the identification of victims is not as simple as creating a new screening tool. It requires a trauma-informed approach that protects the

victim's dignity, provides a safe environment, and builds a relationship based on trust. Next comes effective and efficient ways to gather the right information at the right time to recognize the victimization and to offer intervention.

Rationale (Framework)

Implementing change is never easy, and theoretical frameworks are vital to guide the project's work and serve as a foundation for nurses' professional practice. Three theories selected for this DNP project included: (1) Ernestine Wiedenbach's the Helping Art of Clinical Nursing Theory (Wiedenbach, 1963), chosen to guide changes in how nurses approach potential trafficking victims; (2) Ronald Havelock's Change Theory (Havelock, 1973; Havelock & Zlotolow, 1995; Tyson, 2010), selected to manage a planned organizational change process as well as changes made to the EHR and nursing workflow; and (3) Transformational Leadership Theory (Kuhnert & Lewis, 1987) to serve as the foundation for managing the relationships and implementation aspects of this project.

Wiedenbach's Helping Art of Clinical Nursing Theory.

The Centers for Disease Control and Prevention (CDC, 2019) statistics for violence and abuse are concerning and indicate that many people, not just those trafficked, have a history of trauma. The most recent statistics show one in seven children have experienced abuse or neglect in the past year. Approximately one in four women and one in ten men have experienced intimate partner violence (e.g., sexual abuse, physical violence, and stalking) in the past year. Also, one in five women reported rape, and 12% of these women were less than ten years old at the time of the rape (CDC, 2019).

Victims of trauma should be cared for in a trauma-informed way, approached with care and understanding, as they can be re-traumatized by their experience with health care and health

care providers. Physical examinations, invasive testing, being asked sensitive questions, or removing clothing can trigger anxiety and memories of past abuses. Trauma-informed care recognizes the existence of past traumas and provides physical and emotional safety for the patient based on five principles: safety, choice, collaboration, trustworthiness, and empowerment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

Ernestine Wiedenbach's *The Helping Art of Clinical Nursing* (1963) theoretical framework aligns well with care for this patient population. The patient needs help. The nurse identifies the need for assistance by observing behaviors and symptoms, explores the meaning and cause of the symptoms, and works to restore or extend the patient's ability to cope with the situation impacting their health. For this project, the nurse observes behaviors and symptoms that indicate the potential for human trafficking, asks questions to seek clarification and understanding, and then works to restore or extend the victim's ability to cope by connecting services and support.

There are four constructs, according to Wiedenbach's theory: a philosophy, a purpose, the practice, and the art. A nursing philosophy is based on the dignity and worth of a human being, individuality, and a reverence for life. These components are consistent with the Catholic tradition and core values of Dignity Health, the Jesuit values and mission of the University of San Francisco (USF, 2019), and the Code of Ethics for Nursing (Fowler, 2015). A purpose guides the nurse toward activities for the overall good of patients and is central to the nursing profession; the practice is the nurse's actions to meet the patient's need for help and fulfill the purpose. Lastly, the art centers around the plan to improve the patient's condition; based on an understanding of needs and concerns, the nurse acts based on personal and professional beliefs (Weidenbach, 1963).

The training developed and provided to nursing staff addresses the purpose, practice, and art of caring for trafficking victims. It incorporates trauma-informed care principles while weaving in self-awareness and self-acceptance as essential to personal integrity and self-worth for both the nurse and the patient.

Havelock's Theory of Change.

Several change theories are available, and Ronald Havelock's Theory of Change (1973) is chosen as the second theoretical framework because this project involves planned change. It expands upon Kurt Lewin's (1951) three-stage (unfreezing – change – refreezing) change model, taking a more flexible approach through planning and monitoring (Burns, 2004). Although Lewin's model would have been acceptable, the focus on planning and sustainability was more appealing for this project's type of change.

Havelock's model (1973) involves a six-stage/step process that relies heavily on planning for change and anticipating resistance to that change. The six stages for this model include (a) build a relationship, (b) diagnose the problem, (c) acquire resources for change, (d) select a pathway for the solution, (e) establish and accept change, and (f) maintenance and separation (Havelock & Zlotolow, 1995).

Building a relationship.

In this stage, building a relationship includes a determination that a change is needed. The current practice of screening and documenting indicators of human trafficking is inconsistent. Nurses bring with them varying biases and comfort levels in asking questions specific to trafficking. As a result, potential victims may go unidentified, resulting in missed opportunities to provide safety, advocacy, and connections to support and other health care services.

Diagnosing the problem.

Earlier, the scope of human trafficking globally, nationally, and potentially by patients accessing health care services at a Dignity Health hospital was discussed. The available knowledge was reviewed and synthesized, and a gap analysis was performed (see Appendix D). The problem centers on the consistent and timely recognition of trafficking victims by health care providers and nurses. During this phase, it is essential to help clinicians understand the need for change (Tyson, 2010).

Acquire resources for change.

This stage requires additional data gathering and identification of the resources needed to effect change. Here identification and selection of solutions begin, and a more thorough review of the problem is necessary. For this project, the EHR is a critical solution for the missed identification of human trafficking victims who present to the emergency departments and labor and delivery units.

Selecting a pathway for the solution.

This step in the process is an important one. Here, planning is paramount. Options are narrowed and prioritized, and a solution is selected for implementation. A detailed implementation plan is mandatory to ensure the identification of timelines, required resources, key stakeholders, major milestones and deadlines, and the creation of a budget and communications plan. The project management methodology directs plan execution. The Gantt chart (see Appendix E and Appendix F) and work breakdown structure (WBS) (see Appendix G) provide more detail.

Establish and accept change.

Resistance to change is inevitable, and a part of the change process. Paying attention to detail during this phase of implementation is imperative; focus on minimizing the resistance by removing barriers to the change, appreciating and understanding the impact of the change on those affected by it, and being flexible enough to adjust as the situation requires. The goal is to accept the change and transition to become part of the routine behaviors and practices.

This project's desired behavior change was to have every patient screened for signs of human trafficking in a trauma-informed way. Careful planning and execution of the EHR build and workflow changes minimize the disruption to the nurses' assessment and intake processes. Timely and effective training improves the nurses' comfort level and competencies, and an effective communication plan helps to allay fears. Supporting the new approaches and promptly addressing any concerns or “glitches” with the system fosters the adoption of the desired changes.

Maintenance and separation

Outcome metrics and a formal evaluation process are crucial to success and sustainability. Once the changes are implemented, regular monitoring occurs until the process stabilizes, and an acceptable rate of adoption has been achieved – including the achievement of milestones and deliverables (Martinelli & Milosevic, 2016). Staff and key stakeholders are provided regular follow-up related to the number of victims identified in respective units since implementing the changes and the screening tool's percent completion. This feedback loop provides an avenue for celebration and positive reinforcement of the desired behaviors.

Project implementation was expected to span nine months beginning in January/February 2020 with the final design/build of the EHR screening tool; A 30-day window for training and

communications was scheduled for February/March 2020, followed by a two-week implementation period. Monitoring, data collection, and ongoing evaluation continue until June 2020, with the final analysis and completion of the final report occurring in the third quarter of 2020. Reporting of the outcomes was slated for October 2020. However, an adjustment to the project plan and timeline was required.

Transformational Leadership Theory.

The third theoretical framework incorporated into this project addressed the leadership aspects of relationship management, employee engagement, implementation science, and project management. These are important aspects of change management. James McGregor Burns introduced Transformational Leadership Theory in his book, *Leadership*, published in 1978. Burns focused on the relationship between leader and followers and the importance of motivating each other and creating congruence of values (Burns, 1978). Later, Bernard Bass expanded on Burns' theory to motivation to achieve common goals (Bass, 1985; Kuhnert & Lewis, 1987).

This theory's hallmarks include motivation to achieve common goals, empowerment, effective communication, and the creation of trust. Transformational leadership is mostly applicable in nursing as it commits people to action arising from a shared vision and purpose that benefits the organization and themselves. Transformational leadership theory was used to lead through all the strategies and tactics, to manage each phase of assessment, planning, implementation, and evaluation.

AIM Statement

This project aims to add to the knowledge base and validate the “red flags” or indicators to identify patients at high risk for human trafficking using a standardized, templated screening tool embedded in the electronic health record. Documented identification of human trafficking victims will improve by 20% within 90 days of implementing this tool.

Section III: Methods

Context

Human trafficking is a criminal act, a violation of human rights, human dignity, and an assault against the nursing profession's fundamental principles and code of ethics. A multi-pronged approach was needed to address the problem. Implementation and evaluation of a standardized screening tool in the electronic health record to facilitate the identification of victims were the cornerstones of this project. Through automation, the ability to collect, enter, monitor, aggregate, analyze, and report data enables leaders to identify opportunities for improvement, address gaps in care and services, and validate the “red flag” indications’ sensitivity and specificity.

A project management approach was utilized to support the business and project strategies and manage its various phases. A gap analysis (see Appendix D) identified the internal factors and performance deficiencies, while a strengths, weaknesses, opportunities, and threats (SWOT) analysis (see Appendix H) positioned the project to take advantage of existing strengths and capabilities (Martinelli & Milosevic, 2016). A Gantt chart (see Appendix E and Appendix F), work breakdown structure (WBS) (see Appendix G), and budget (see Appendix I) were created to guide the parameters and scope of the project.

Key stakeholders played significant roles in the project and the success of the change. They were identified, included in the project planning, implementation, evaluation, and sustainability phases. For this project, key stakeholders included the nursing and social services staff and leaders of the emergency departments and labor and delivery units, hospital and system leaders, clinical educators, clinical informaticists, law enforcement, EHR vendor partners, and

victims. Clinical staff in care coordination, behavioral health, and the medical staff are not the focus of this phase of the project but will be included in future iterations and sustainment efforts.

Dignity Health is a nationally recognized leader for its Human Trafficking Response Program (Minemyer, 2017). Changes to the electronic health record were an integral component of this project. Dignity Health currently uses Cerner *Millennium*[®]/ PowerChart[®] (“PowerChart”) (Cerner, 2019) as the enterprise standard; it operates on two separate but similar domains. Creating a standardized screening tool and embedding it into PowerChart[®] impacts all acute care hospitals in both domains. Changes cannot be isolated to a single unit or facility, and therefore, this project will be implemented enterprise-wide. This was a process improvement project, and it did not include human subjects research. A signed Statement of Non-Research Determination Form was submitted to and approved by the University of San Francisco School of Nursing and Health Professions (see Appendix J). Due to the global pandemic's impact on the project's trajectory, a Statement of Non-Research Determination form for submission to Dignity Health (see Appendix K) will be submitted at a later date. A letter of support for the project was obtained from CommonSpirit Health, as the sponsoring organization (see Appendix L).

Interventions

Nurses collect administrative and clinical data as part of the nursing assessment process. These data are often used to screen patients for infectious diseases, social determinants of health, psychosocial needs, and signs of abuse or neglect, to name a few. A standardized assessment and documentation tool was planned to be built into the electronic health record and incorporated into the nursing assessment process and workflow. The data collected from this tool would correlate the screening criteria to patients identified as being trafficked and compare these “red

flags” to those themes identified in current practice. However, the global pandemic disrupted the work plan, and this portion of the DNP project was suspended.

A white paper recently published by Polaris (2018) revealed that 68% of survivor respondents surveyed reported the emergency department as the most commonplace they used to access health care. In the Emergency Department (ED) and Labor and Delivery (L&D) units, nurses collect a lot of this vital information through the triage process; inpatient nurses collect this information through an Admission History. The current data collection method and documentation require clinical staff, including nurses, to input information into the integrated, enterprise-wide electronic health record platform, Cerner *Millennium*[®] (Cerner, 2019), based on individual practices and workflows. The proposed solution embeds a screening tool template that standardizes the information collected for each patient at the same point in the assessment process.

Purpose, processes, and activities of the entity.

The project was planned to be conducted in emergency departments and labor and delivery units of Dignity Health acute care hospitals located in Arizona, Nevada, and California (see Appendix A). These hospitals range from critical access hospitals with less than 25 licensed beds to large academic medical centers with more than 500 licensed acute care beds. Their locations range from very rural sites in northern and central California to large urban centers like Los Angeles, CA, Phoenix, AZ, Las Vegas, NV, and San Francisco, CA.

Project management.

A change process requires organization, clarity, and a plan. The project plan was developed using the project triangle model (Bonnell, & Smith, 2018) and general project management principles described in Martinelli and Milosevic (2016). This plan included a

PICOT question, gap analysis, a Gantt chart, a work breakdown structure (WBS), identification of key stakeholders, outcome measures, roles and responsibilities, communication plan, and budget.

Gap analysis.

The gap analysis described the current state and compared it to the desired performance. As a tool, it aided in identifying problems, priorities, risks. It helped to provide clarity to the problem identification and definition, as well as action steps to elevate the performance of the organization. The gap analysis delivered a structured way to identify solutions to improve performance, particularly related to documentation (consistency and completeness) and the knowledge and skills gaps among nurses related to the recognition and identification of victims. Appendix D depicts the gap analysis results and includes identifying the issue(s), current state performance, future/desired state performance, focus areas, action items, and priority.

The significant gaps identified fall into three categories: (1) consistent identification of HT victims, (2) staff skills, abilities, and behaviors, and (3) communication and feedback loops. Inconsistent identification of HT victims was due to a lack of a standardized set of objective and subjective data and assessment parameters to indicate the potential for trafficking and their documentation in the EHR. Staff attitudes and behaviors affected their ability to recognize trafficking victims and approach them in a trauma-informed way. Equally important was the need for timely communication between clinicians about their assessment findings, identifying potential victims, and getting them to a safe place and connected to resources. Currently, the EHR does not support these processes; it depends on individual clinician performance and practice.

Gantt chart.

A Gantt chart is a scheduling tool that depicts all the necessary activities, sequencing of activities, timeframes and durations, key milestones, resource requirements, and expected completion dates. It was developed based on the work breakdown structure (see Appendix G), with details added as the project required. The Gantt chart incorporated the responsibilities, timelines, milestones, and completion status of each critical activity (see Appendix E and Appendix F). There were several major milestones identified for this project, including (a) establishment of baseline data for the number of identified HT victims, (b) EHR changes including the identification of changes to the architecture and data fields, design and build of the screening tool template, testing of the functionality, and then placing the changes into production, (c) training of staff which included curriculum development, build and distribution of the training module in the learning management system (LMS), and completion of the training, (d) development and implementation of the communication plan, (e) implementation and “go live” of the screening tool, (f) project monitoring and evaluation, (g) data collection and analysis, (h) feedback to key stakeholders, (i) celebration, (j) project close-out, and (k) sustainability plan following the completion of this DNP project.

Work breakdown structure.

Each project is unique, and to manage it effectively, the project's scope must be defined. The WBS (see Appendix G) organized, grouped, and aligned the project elements with the outcomes (Martinelli and Milosevic, 2016). In this way, the scope of the project was depicted and defined in its entirety. The WBS was designed to provide detailed, hierarchical tasks or work packages that were assigned, monitored, tracked, and evaluated against desired outcomes and deliverables. For the DNP project, the WBS was organized by the project life cycle. It was

selected rather than another method of structuring the work due to the plan's nature and complexity. As the project progressed, additional detail levels were added. Using the nursing process as a guide, the WBS was built in a top-down fashion, grouping related outcomes for each phase of the project.

Responsibilities and communication plan.

An essential part of any project plan is identifying vital team members and delineating roles and responsibilities. Appendix M outlined the key roles and responsibilities for this project. A project communication plan created a platform and conduit for information flow, articulation of the project's expectations, and increased visibility. Additionally, the communication plan (see Appendix N) provided the avenue for feedback; it provided updates, ensuring the project and its goals stay aligned. The communication plan included a cadence and a method or channel for information flow.

SWOT analysis of current state.

As described earlier, a gap analysis (see Appendix D) was completed to evaluate internal performance deficiencies and aid in achieving short-term goals. In contrast, strengths, weaknesses, opportunities, and threats (SWOT) analysis of the current state (see Appendix H) was conducted to assess the company against its peers or competition, identifying opportunities in the environment external to the organization or project and for long term planning.

Budget.

Developing a budget for the project was crucial. It aligned the appropriate resources to the necessary activities to achieve the project's desired outcomes. It was a way to manage unnecessary costs that could jeopardize the completion of the project. The project budget (see Appendix I) reflected the anticipated costs associated with the clinical informatics and

information technology (IT) architects to design and build the EHR functionality, conduct testing, and place it into the production environment for use by clinicians. Additionally, the budget reflected costs associated with creating, designing, and developing the interactive learning content and the staff time to complete the training. There were no anticipated revenues related to this project, nor any cost avoidance opportunities identified.

Benefit-cost analysis.

An essential part of project planning is the benefit-cost analysis; it can be an important management tool to determine the feasibility, justification, and soundness of a project proposal. Typically, a project should deliver optimum organizational benefits to be successful, meaning the benefit(s) should outweigh the costs. The benefit can come in the form of hard benefits traceable to the profit and loss statement (e.g., increased revenue generation, realized expense savings), soft benefits (e.g., non-financial benefits such as cost avoidance, improved quality), one-time benefits, and productivity benefits (e.g., the reduced effort required to perform a task). The costs and benefits of implementing a project were analyzed to determine whether the project would positively or negatively affect the organization. The accuracy of the benefit-cost analysis was dependent upon the accuracy of the inputs, the levels of risk and uncertainty, the valuation of intangibles, external factors (e.g., inflation, interest rates, pandemics), and the application of all relevant costs and benefits using the time value of money spent (Waxman, 2018). Appendix O provided a benefit-cost analysis based on soft benefits, as there are no hard benefits identified at this time.

Due to this project's nature, it was difficult to calculate an accurate cost-benefit ratio. The benefits expected from implementing a standardized template for identifying human trafficking victims are difficult to measure. The true prevalence and costs of human trafficking to society

and the communities served by Dignity Health are unknown. However, based on available data, estimates of cost-benefit were calculated using the average profit generated by a trafficking victim (Human Rights First, 2017) (See Appendix O).

The data gathered from this study contribute to the broader understanding and body of evidence related to prevalence and costs. Although difficult to quantify or monetize, the costs and benefits must be considered even if the benefits are related to increased awareness and improved understanding, better transparency, improved access to healthcare, and social justice. The protection of human rights, prevention of violence, abuse and exploitation, and improvements in access to support services are difficult to describe or define in monetary terms and, therefore, priceless. Instead, the realization of these benefits aligns with the organization's mission of improving the health of the people served, including those who are vulnerable.

Nature of the project.

Since the project was paused due to the global pandemic's impact, this portion of the project was not executed. When able to resume this project, will utilize a quality improvement based retrospective record review using data extracted from the EHR, with the emergency departments and labor and delivery units, the primary locations to be studied. No patients will be interviewed. This project's inclusion criteria include patients who are fifteen years of age or older and who present to a Dignity Health facility seeking care in either an ED or labor and delivery unit. Exclusion criteria (see Appendix P) consist of (a) patients younger than fifteen years of age, (b) patients who do not present to a Dignity Health facility or who present to a department other than the ED or L&D seeking care, (c) patients who present to a Dignity Health facility in cardiopulmonary arrest or (d) patients with incomplete screening. The current ad hoc forms used for intake for the ED, L&D, and inpatient units will be modified to include all ten

“red flags” for human trafficking (see Appendix Q) published by the American Hospital Association (AHA) in collaboration with Catholic Health Initiatives (AHA, 2018).

Once the changes are made to the required forms in the EHR, nurses will receive training to familiarize themselves with the newly required documentation fields and the importance of ensuring completeness of the documentation. Reports will be created to identify patients who screened for human trafficking. Then retrospective chart reviews will be conducted to determine the frequency each red flag criterion was selected, correlations to identifying victims at high risk for human trafficking, and referral to community resources. All patients who meet inclusion criteria (see Appendix P) presenting to the emergency departments or labor and delivery units of Dignity Health hospitals between the go-live date in February 2020 through June 30, 2020, are screened.

Implementation Barriers

Late in 2019, the initial outbreak in Hubei Province, Wuhan, China of the severe acute respiratory syndrome (SARS) coronavirus 2 (SARS-CoV-2) virus set into motion a global pandemic has since changed nearly every aspect of life. On January 22, 2020, a patient from Washington state was confirmed to have COVID-19 (Harcourt, 2020). Hence, it began a swift and rampant spread of the virus across the United States (U.S.).

In February 2020, concerns about the COVID-19 virus reached new levels within Dignity Health as attention turned to emergency preparedness and crisis management planning within each hospital and across the enterprise. All non-essential information technology (I.T.), digital and clinical informatics projects were halted – funding and resources withdrawn. All education and training, not specific to preparing staff to perform and manage effectively in a crisis, were suspended or postponed. As states issued their public health emergency declarations, California

on March 4, 2020 (State of California, 2020), Arizona on March 11, 2020 (State of Arizona, 2020), and Nevada on March 12, 2020 (State of Nevada, 2020), the reprioritization of efforts, resources and capabilities essentially stopped all implementation efforts of this DNP project. Unfortunately, it has been more than six months since the impact of COVID-19 was felt, operational changes were necessitated, I.T. resources have been reduced, and the moratorium on I.T. projects continues.

Study of the Interventions: Impact of Interventions

The project implementation plan was rewritten for the standardized screening tool in preparation for future implementation. Implementation and dissemination of the interactive learning modules occurred in September 2020. The modules were assigned only to ED staff in three hospitals in southern California, and they had thirty days to complete them. Results demonstrated improved comprehension compared to baseline, as evidenced by a successful pass rate of 80% or greater. The clinical significance of this intervention suggests that by increasing awareness through improved knowledge about human trafficking “red flags” and trauma-informed care, clinicians are more likely to recognize and identify victims or potential victims of sex or labor trafficking who present to the ED for care and services

Study of the Interventions: Processes and Outcome Measures

Quality measures for studying processes and outcomes of the intervention were chosen to monitor compliance using the tool and correlations between the ten selected “red flag” indications and identification of trafficking victims. The outcome measures proposed include:

- Completion rates of required training through the Learning Management System,
- Frequency of selection for each of the “red flag” indicators of human trafficking,

- Frequency of observable risk factors or signs/symptoms of abuse, neglect, or violence,
- Percent completion of the screening form,
- The number of victims identified and # times services offered to the victim.
- Correlation between indicator(s) and victims identified.

Analysis

Implementation of the EHR's standardized screen tool did not occur; therefore, data collection could not be conducted, nor analysis performed. Once the project resumes, data will be collected electronically using the electronic health record for victim screening and identification data and the learning management system for training completion. Data will be analyzed using data analytics and statistical tools like Microsoft Excel (Microsoft Corporation, 2019) and IBM® SPSS® Statistical Software (IBM, 2019). A benefit-cost analysis based on interactive training is considered the “soft” or other more difficult to quantify and measure benefits to society. This analysis (see Appendix O) demonstrates a reduction in illegal profits for every decrease in the number of trafficking victims. Another return on investment (ROI) consideration is social ROI, which cannot be reflected or quantified for financial statements. Instead, social ROI may have more lasting impacts on the organization’s profitability (e.g., brand value), the socio-economic health of a community, or the long-term impact on the health care system or the victims themselves (Lopez, 2019).

Statistical analysis.

No statistical analysis related to the validation of the “red flags” was performed. However, comprehension rates following staff completion of the interactive learning modules

(see Appendix R) demonstrated a five percent improvement (87.1% versus 95.1% respectively) although not statistically significant ($p = .6018$).

Clinical Significance.

EHR data.

Once the project resumes, the data will be collected and reported with personal health information identifiers removed. The de-identified data will be provided by department and by facility, with the ability to do aggregate analysis across the system by service line (e.g., emergency department, labor, and delivery department), by service area (e.g., all the Dignity Health hospitals in a designated geographic region or state), and for the entire system. Each “red flag” indicator will be listed as a separate data point in the reports to allow correlation studies like a paired *t*-test and chi-square test. Descriptive, qualitative, and inferential statistics and data analysis will be used to describe the project findings. A biostatistician within Dignity Health is available if more advanced analyses are required, although not anticipated. A proposed data table example is provided to illustrate how the data is to be reported (see Appendix S). Baseline data (see Appendix T) is used to gauge the achievement of the project aim.

This work's clinical significance is the improvement in awareness, recognition, and identification of commercial sexual and labor exploitation victims. Unfortunately, the actual number of victims is unknown, so increasing the number of identified victims is just scratching the surface of a widespread and largely undetected problem. Clinicians can play a significant role in ending the cycle of violence and exploitation. This project and other anti-trafficking programs strive to reduce the prevalence and impact (e.g., psychological, physical, spiritual, emotional, and economic) of this global, extremely lucrative criminal activity with its high human and societal toll.

Ethical Considerations and Conflicts of Interest

Moral and legal accountability accompanies professional nursing practice where there is a fiduciary responsibility for nurse-patient relationships built on trust (Grace, 2018). Ethical professional practice is directed by the profession, guided by values, and delivered in the context of individuals, society, and institutions. Moral values such as justice, beneficence, non-maleficence, and autonomy are part of the nursing code of ethics (ANA, 2016). Adherence to this code of ethics is essential when caring for or conducting research on humans. The University of San Francisco has Jesuit values at its foundation: caring for the whole person, a commitment to diversity, and being and creating people for others (USF, 2019). Similarly, CommonSpirit Health, with roots in the Catholic tradition and seventeen sponsoring congregations, has its values centered on integrity, collaboration, compassion, inclusion, and excellence (CommonSpirit Health, 2019a).

In September 2019, the USF DNP department determined that this project met the guidelines for an evidence-based change in practice project outlined in the DNP statement of determination form (see Appendix J) and approved as non-research. There are no identifiable issues or conflicts of interest noted for this project. Whenever studies are conducted using human subjects' data, there is potential for ethical and privacy issues. Safeguards were planned to minimize these risks. Reports did not include patient identifiers, and only the project sponsor had access to system-wide data. Facility department leaders will access their department data for clinical follow up, but not for the facility aggregate nor the service area or system-level data. Any potential ethics concerns or conflicts of interest are addressed with the organization's appropriate oversight body where the situation arises. If the matter involves a system concern, it will be escalated to the applicable system level leader.

Section IV: Results

Results

As a result of the COVID-19 global pandemic, no results were obtained related to screening or identifying trafficking victims or validating the “red flags”; therefore, there are no results to report this aspect of the project. Instead, other activities to support the identification and provision of services for suspected victims and survivors of human trafficking were pursued to avoid momentum loss (see Section VII for further discussion).

Section V: Discussion

Summary

The declaration of a global public health crisis and its far-reaching impact on the health care system of the United States, and for Dignity Health, has exacerbated and highlighted problems in our health care system: (a) crisis in insurance coverage, (b) racial, ethnic and health disparities impacting access and outcomes, (c) a crisis in public health related to identification, management and control the pandemic, and (d) significant financial losses for providers of health care related to demand and reimbursement challenges (Blumenthal, Fowler, Abrams, & Collins, 2020).

In addition to the impact on systems and infrastructure, the coronavirus pandemic has tested leadership (Hatami, Sjatil, & Sneader, 2020). Dealing with uncertainty, changing priorities, isolation, feelings of powerlessness and fatigue, and a need for innovation and resilience can challenge any leader. As initially designed, the DNP project could not proceed, yet it was clear that the work needed to continue to address the necessary improvements in identifying trafficking victims. Section VII discusses the alternative work that occurred and how leadership played a crucial role in effecting change during this pandemic.

Key findings.

As a result of the COVID-19 global pandemic, there are no results related to the EHR screening tool, and therefore, there are no key findings to report. The recent release of the interactive learning modules requires additional data collection and analysis before conclusions are drawn.

Dissemination plan.

As a result of the COVID-19 global pandemic, the project was not fully implemented; preliminary results were obtained, and therefore, the communication plans and dissemination plan were not initiated. However, there is a plan to continue this project beyond the term of this DNP program. Dissemination of findings to key stakeholders and potential philanthropic, community, and research partners, are planned. Information sharing occurs via internal and external channels as well as publications as appropriate.

Limitations

Combating human trafficking is an organizational priority. This DNP project aligned with the strategic vision and strategic plan for the Anti-violence/Human trafficking Prevention and Response Program for Dignity Health. Potential limitations of the project include (a) the inability for staff to overcome their personal biases related to victims of violence and trafficking, (b) reluctance of victims to accept support services when offered, and (c) an insufficient number of victims (small sample size) identified in any particular hospital or service area to make the analysis and correlations statistically significant. An actual limitation included the inability to complete the EHR build and implementation of the changes to the screening process due to resource constraints resulting from the sustained financial and human capital impact of the public health emergency on the organization. However, the clinical and societal implications could be considerable. Clinicians play a significant role in reducing the number and negative individual and societal consequences of this public health crisis known as modern-day slavery.

Conclusions

When implemented, this project had and will have in the future, both short-term and long-term implications for patients served by Dignity Health and for all victims of forced labor

and commercial sex trafficking across the country. In the short-term, automation will improve what are currently very labor-intensive and inconsistent processes for victim identification and data collection. In the long-term, validation of the “red flag” indicators will contribute to the broader body of knowledge. Perhaps correlations can be drawn that indicate a causal link between an indicator or combination of indicators to identify a victim of trafficking. Improved education and training can help build a health care system that supports a culture of caring that is trauma-informed, patient-centered, and nurse-led.

Section VI: Other Information**Funding**

Dignity Health provided funding for the original project and the subsequent related projects and their associated expenses as part of the Human Trafficking Response Program's operational budget. Labor and supply expenses were provided in-kind to this DNP project and part of the HTR program's everyday activities.

Section VII: Leadership and the novel coronavirus 2019 (COVID-19)

Human trafficking victims are often hiding in plain sight, and identification is challenging under the best circumstances. The impact of the COVID-19 pandemic makes the identification of these individuals even more difficult. The very measures put in place to protect public safety during a public health crisis (e.g., curfews, mandatory isolation, and quarantine, restricted travel, border closures, increased police presence) have driven these crimes further underground (United Nations, 2020). Those who are most vulnerable are at greater risk of exploitation. Many have lost their sources of income and access to food. Children have been forced into the streets searching for shelter and nourishment. Domestic or interpersonal violence levels are known to increase during a crisis as victims are forced to be locked down with their abusers.

Despite the fact the DNP project was suspended, it was clear that addressing these vulnerable populations needs to continue. Although creating a standardized, templated screen tool is not currently feasible, other activities supporting the broader project objectives were pursued.

Other Activities

Despite the inability to implement the proposed changes to the electronic health record and measure the impact of the changes, other activities supporting human trafficking response and recognition that began before the global pandemic's emergency declaration were identified and prioritized. In response to California Senate Bill 225 (SB 225) (State of California, 2017), human trafficking victim outreach posters (see Appendix U) were created, co-branded with the National Survivor Network (NSN), and distributed to Dignity Health facilities to display in emergency departments, urgent care centers, and labor and delivery departments. The posters

include the toll-free Human Trafficking Hotline number and translated into the top nine threshold languages (Armenian, Chinese, Hmong, Korean, Punjabi, Russian, Spanish, Tagalog, and Vietnamese) and branded based on Dignity Health standards. Dignity Health was awarded three federally funded grants from the United States Department of Justice (DoJ) Office for Victims of Crime (OVC) (see Appendix V for a summary of these grants) in 2018. Due to a delay in obtaining IRB approval, work started on these grants in late 2019 and early 2020.

Under the leadership of the Office of Mission and Advocacy, efforts are being focused on engaging major corporations in industries (e.g., travel and tourism, major retailers, transportation, and technology) that have the ability and opportunity to (1) address human trafficking and child sex exploitation, and (2) promote organizational commitment to prevent, identify and respond to human trafficking. Efforts have also extended to public policy, monitoring opportunities to influence legislation related to violence and human trafficking at the state and federal levels.

Clearly, as an executive nurse leader, the need to reframe the challenge and manage change despite the uncertainty ahead became evident. Using Havelock's Theory of Change and Transformational Leadership theory, steps were taken to continue forward progress. According to the Transformational Leadership theory, motivation to achieve common goals, empowerment, effective communication, and trust creation are hallmarks. These principles were used to re-imagine the future work, including the creation of a shared vision and purpose.

There are parts of the DNP project that could be isolated and reprioritized. Initially, Phase I of the project centered on creating and implementing the templated screening tool and staff training. Phase II, to be done after completion of the DNP project, was intended to revise and update the existing HT resource materials, including the staff training modules and incorporate

interactive components to make them more appealing and engaging. Creation and deployment of the three learning modules, *Human Trafficking 101*, *Trauma-Informed Care*, and the *PEARR Tool*, was done without impacting IT resources or placing a burden on clinical staff for training time. Woven throughout this process was the application of Havelock's Theory of Change.

Building a relationship and diagnosing the problem.

Building a relationship includes a determination that a change is needed. The COVID-19 pandemic created a barrier that became the impetus for change. The DNP project could not address the current practice of screening and documenting human trafficking indicators, so the change process's training and awareness components became the focus and the intervention for this change in practice project. According to the studies previously cited, training helps to improve awareness and identification of the indicators and risk factors for victims at high risk for sexual and labor exploitation.

Acquire resources for change.

An assessment of the work, resources, and time requirements was completed. Resources were identified for both internal and external sources. They included subject matter experts to review the current content and make revisions, and an instructional designer to create the interactive learning modules based on the revised content.

Selecting a pathway for solution.

Once the solution was determined, a Gantt chart, combined with the work breakdown structure, was created to reflect the key steps, timeline, and milestones (see Appendix E). Implementation began in February 2020 with a review of the current content and revisions to modernize the information. A budget of \$70,000 was approved to create three interactive modules to include videos, voice-over narration, and interactive activities to assess

comprehension. An external instructional designer was contracted, and a Statement of Work was executed with key deliverables and timelines. Two of the three modules have been completed, and the third module, *Human Trafficking 101*, is currently in process (see Appendix R).

Establish and accept change.

Once completed, the three updated learning modules will be uploaded to the Learning Management System and assigned to staff. Since the inception of the Human Trafficking Response Program (Dignity Health, 2019a), over 20,000 staff, physicians, and volunteers have received human trafficking training. The new training modules will serve to refresh and build upon previous learnings. Statistics related to the number of victims identified by staff will continue to be collected monthly and analysis made about whether this training has improved awareness and recognition of these vulnerable individuals.

Implications for advanced nursing practice.

More than 40 million people worldwide are forced into sexual or labor exploitation (ILO, 2017). Their dignity and freedom are deprived, and they suffer profound physical (e.g., injuries and illness) and psychological effects (e.g., mental health issues, substance use disorders). Human trafficking is found in every state in the U.S. and every continent globally; it transcends all demographics, social classes, and populations. According to a report published by Human Rights First (2017), traffickers earn approximately \$150 billion per year, with sexual exploitation yielding a return on investment between 100% to 1,000%.

Between 28% and 87.8% of trafficking victims access the health care system while under the control of their abuser; many go unrecognized as victims (Baldwin et al., 2011; Becker & Bechtel, 2015; Dovydaitis, 2010; Lederer & Wetzel, 2014;). Human trafficking, as a public health emergency and an egregious violation of human rights, has been a focus of the American

Nurses Association (ANA) in 2008, 2010, and 2016 (ANA, 2008; ANA, 2010; ANA, 2016).

The ANA's position statement on ethics and human rights is the foundation for all other position statements affecting nursing practice. Nurses are uniquely positioned to protect and promote human rights in every practice setting. Additionally, nurses have a professional and moral obligation to report suspected human trafficking cases, be informed and knowledgeable of ways to identify victims, and advocate for and provide care in a trauma-informed, victim-centered, and collaborative manner.

Advanced practice nurses, especially those in executive leadership positions, must create practice environments that support nursing's ethical practice. Nurses provide care based on need and without bias, recognizing every individual's inherent worth and dignity. Through applying the American Organization of Nursing Leadership (AONL) competencies, nurse leaders are uniquely qualified to combat human trafficking through advocacy and influencing nursing practice across the care continuum (Clemmons-Brown, 2019).

Section VIII: References

References

- American Hospital Association. (2018). Human trafficking: 10 red flags that your patient could be a victim. Retrieved from <https://www.aha.org/system/files/2018-07/human-trafficking-infographic.pdf>.
- American Nurses Association. (2008). RN delegates to ANA's biennial meeting take action to work toward greater nurse retention, address public health issues. In: *News release*. American Nurses Association.
- American Nurses Association. (2010). The nurse's role in ethics and human rights: Protecting and promoting individual worth, dignity, and human rights in practice settings. Silver Springs, MD: Nursebooks.
- American Nurses Association. (2016). Position statement: The nurse's role in ethics and human rights: Protecting and promoting individual worth, dignity, and human rights in practice settings. Retrieved from <https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/ethics-and-human-rights-protecting-and-promoting-final-formatted-20161130.pdf>
- Armstrong, S. (2017). Instruments to identify commercially sexually exploited children: Feasibility of use in the emergency department setting. *Pediatric Emergency Care*, 33(12), 794-799. <https://doi.org/10.1097/PEC.0000000000001020>
- Armstrong, S., Greenbaum, V. J., López, C., & Barroso, J. (2019). Preparedness to identify and care for trafficked persons in South Carolina hospitals: A state-wide exploration. *Journal of Human Trafficking*, 1-28. <https://doi.org/10.1080/23322705.2019.1603747>

- Baldwin, S. B., Eisenman, D. P., Sayles, J. N., Ryan, G., & Chuang, K. S. (2011). Identification of human trafficking victims in health care settings. *Health and Human Rights, 13*(1), 36-49. Retrieved from http://publichealth.lacounty.gov/ha/present/Staff_researchpapers/Susie_Baldwin_Articles/BaldwinHHR2011.pdf
- Bass, B. M. (1985). *Leadership and performance beyond expectations*. New York, NY: Free Press.
- Beck, M. E., Lineer, M. M., Melzer-Lange, M., Simpson, P., Nugent, M., & Rabbitt, A. (2015). Medical providers understanding of sex trafficking and their experience with at-risk patients. *Pediatrics, 135*(4), e895-e902. <https://doi.org/10.1542/peds.2014-2814>
- Becker, H. J., & Bechtel, K. (2015). Recognizing victims of human trafficking in the pediatric emergency department. *Pediatric Emergency Care, 31*(2), 144-147. Retrieved from <https://pdfs.semanticscholar.org/cb76/0656821e2124dc8b544732c3d1c701735828.pdf>.
- Bespalova, N., Morgan, J., & Coverdale, J. (2016). A pathway to freedom: An evaluation of screening tools for the identification of trafficking victims. *Academy of Psychiatry, 40*, 124-128. <https://doi.org/10.1007/s40596-014-0245-1>
- Bigelsen, J., & Vuotto, S. (2013). Homelessness, survival sex and human trafficking: As experienced by the youth of Covenant House New York. Retrieved from <http://www.covenanthouse.org/sites/default/files/attachments/Covenant-House-trafficking-study.pdf>
- Blumenthal, D., Fowler, E. J., Abrams, M., & Collins, S. R. (2020, October 8). Covid-19 – Implications for the health care system. *The New England Journal of Medicine, 383*, 1483-1488. <https://doi.org/10.1056/NEJMs2021088>

- Bonnel, W., & Smith, K. V. (2018). *Proposal writing for clinical nursing and DNP projects*. (2nd ed.). New York, NY: Springer Publishing.
- Briere, R., & Simon, P. (2014). *Confronting commercial sexual exploitation and sex trafficking of minors in the United States: A guide for providers of victim and support services*. Washington, DC: National Academies Press.
- Burns, B. (2004). Kurt Lewin and the planned approach to change: A re-appraisal. *Journal of Management Studies*, 41(6), 977-1002. <https://doi.org/10.1111/j.1467-6486.2004.00463.x>
- Burns, J. M. (1978). *Leadership*. New York, NY: Harper & Row.
- Center for Substance Abuse Treatment. (2014). *Treatment improvement protocol (TIP) Series, No. 57: Trauma-informed care in behavioral health services*. Report no.: SMA 14-4816. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Centers for Disease Control and Prevention. (2019). Violence prevention. Retrieved from <https://www.cdc.gov/violenceprevention/index.html>
- Cerner Corporation. (2019). Solutions: Hospitals and health systems. Retrieved from <http://www.cerner.com/solutions/health-systems>
- Chang, K. S. G., Lee, K., Park, T., Sy, E., & Quach, T. (2015). Using a clinic-based screening tool for primary care providers to identify commercially sexually exploited children. *Journal of Applied Research on Children*, 6(1), Retrieved from <http://digitalcommons.library.tmc.edu/childrenatrisk/vol6/iss1/6>

- Chisolm-Straker, M., Baldwin, S., Gaigbe-Togbe, B., Ndukwe, N., Johnson, P. N., & Richardson, L. D. (2016). Health care and human trafficking: We are seeing the unseen. *Journal of Health Care for the Poor and Underserved*, 27(3), 1220-1233. <https://doi.org/10.1353/hpu.2016.0131>
- Chisolm-Straker, M., Sze, J., Einbond, J., White, J., & Stoklosa, H. (2019). Screening for human trafficking among homeless young adults. *Children and Youth Services Review*, 98, 72-29. <https://doi.org/10.1016/j.childyouth.2018.12.014>
- Clemmons-Brown, C. A. (2020, March 10). Addressing human trafficking through nurse leadership: Application of AONL competencies. *Nurse Leader*. <https://doi.org/10.1016/j.mnl.2020.01.005>
- CommonSpirit Health. (2019a). About us. Retrieved from <https://commonspirit.org/about-us/>
- CommonSpirit Health. (2019b). Violence and human trafficking prevention and response program summary. Retrieved from <https://commonspirit.org/united-against-violence/>
- CommonSpirit Health. (2020a). *Human trafficking 101: Dispelling the myths* [Interactive learning module]. San Francisco, CA.
- CommonSpirit Health. (2020b). *PEARR: Five steps to victim assistance in health care settings* [Interactive learning module]. San Francisco, CA.
- CommonSpirit Health. (2020c). *Trauma-informed patient care and services* [Interactive learning module]. San Francisco, CA.
- Dank, M., Yahner, J., Yu, L., Vasquez-Noriega, C., Gelatt, J., & Pergamit, M. (2017). Pretesting a human trafficking screening tool in the child welfare and runaway and homeless youth systems. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/93596/pretesting_tool_1.pdf

Dignity Health. (n.d.). About us. Retrieved from <https://www.dignityhealth.org/about-us/press-center/about-dh>

Dignity Health. (2014). Our Mission integration standards + indicators. Retrieved from https://www.dignityhealth.org/-/media/cm/media/documents/PDFs/OUR_1DH_MissionIntegration_Standards_Indicators_2014.ashx?la=en&hash=8A8669C5846E9EF2459C9C37E4B43E41CDEDFC48

Dignity Health. (2018). Internal documents: Fiscal year-end financial report.

Dignity Health. (2019a). Human trafficking response: Take a stand against human trafficking. Retrieved from <https://www.dignityhealth.org/hello-humankindness/human-trafficking>

Dignity Health. (2019b). PEARR Tool. Trauma informed approach to victim assistance in health care settings. Retrieved from <https://www.dignityhealth.org/hello-humankindness/human-trafficking/victim-centered-and-trauma-informed/using-the-pearr-tool>.

Dols, J. D., Beckmann-Mendez, D., McDow, J., Walker, K., & Moon, M. D. (2019). Human trafficking victim identification, assessment, and intervention strategies in south Texas emergency departments. *Journal of Emergency Nursing, 45*(6), 622-633. <https://doi.org/10.1016/j.jen.2019.07.002>

Dovydaitis, T. (2010). Human trafficking: Role of the health care provider. *Journal of Midwifery Womens Health, 55*(5), 462-467. <https://doi.org/10.1016/j.jmwh.2009.12.017>

Ertl, S., Bokor, B., Tuchman, L., Miller, E., Kappel, R., & Deye, K. (2019). Healthcare needs and utilization patterns of sex-trafficked youth: Missed opportunities at a children's hospital. *Child Care Health Development, 46*, 422-427. <https://doi.org/10.1111/cch.12759>

Fowler, M. (2015). *Guide to the ANA Code of Ethics for Nurses with Interpretive Guidelines: Development, Interpretation and Application*. (2nd. Ed.). Silver Springs, MD:

Nursingbooks.org.

Goldberg, A. P., Moore, J. L., Houck, C., Kaplan, D. M., & Barron, C. E. (2017). Domestic minor sex trafficking patients: A retrospective analysis of medical presentation.

Pediatric Adolescent Gynecology, 30, 109-115.

<https://doi.org/10.1016/j.jpag.2016.08.010>

Gorbalenya A.E., Baker, S.C., Baric, R.S., de Groot, R.J., Drosten, C., Gulyaeva, A.A., . . .

Ziebuhr, J. (2020, March). The species Severe acute respiratory syndrome-related coronavirus: classifying 2019-nCoV and naming it SARS-CoV-2. *Nature*

Microbiology. 5(4), 536–544. <https://doi:10.1038/s41564-020-0695-z>

Grace, P. J. (2018). *Nursing ethics and professional responsibility in advanced practice* (3rd ed.).

Burlington, MA: Jones & Bartlett.

Greenbaum, V. J., Dodd, M., & McCracken, C. (2016). A short screening tool to identify victims of child sex trafficking in the health care setting. *Pediatric Emergency Care*, 34(1), 33-

37. <https://doi.org/10.1097/PEC.0000000000000602>

Greenbaum, V. J., Livings, M. S., Lai, B. S., Edinburgh, L., Baikie, P., Grant, S. R., . . . Self-

Brown, S. (2018). Evaluation of a tool to identify child sex trafficking victims in multiple healthcare settings. *Journal of Adolescent Health*, 63, 745-752.

<https://doi.org/10.1016/j.jadohealth.2018.06.032>

Hatami, H., Sjatil, P. E., & Sneader, K. (2020, May 28). The toughest leadership test. Retrieved

from <https://www.mckinsey.com/featured-insights/leadership/the-toughest-leadership-test>

- Havelock, R. (1973). *The change agent's guide to innovation in education*. Englewood Cliffs, NJ: Educational Technology.
- Havelock, R. G., & Zlotolow, S. (1995). *The change agent's guide* (2nd ed.). Englewood Cliffs, NJ: Educational Technology Publications.
- Human Rights First. (2017, January 07). Human trafficking by the numbers. Retrieved from <https://www.humanrightsfirst.org/resource/human-trafficking-numbers>
- IBM. (2019). IBM SPSS Software. Retrieved from <https://www.ibm.com/analytics/spss-statistics-software>
- International Labour Organization. (2014). Profits and poverty: The economics of forced labor. Retrieved from https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_243391.pdf
- International Labour Organization. (2017). Forced labour, modern slavery and human trafficking: Facts and figures. Retrieved from <https://www.ilo.org/global/topics/forced-labour/lang--en/index.htm>
- Johns Hopkins Resource Center. (2020). COVID-19 dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU). Retrieved from <https://coronavirus.jhu.edu/map.html>
- Kaltiso, S. O., Greenbaum, V. J., Agarwal, M., McCracken, C., Zmitrovich, A., Harper, E., & Simon, H. K. (2018). Evaluation of a screening tool for child sex trafficking among patients with high-risk chief complaints in a pediatric emergency department. *Academic Emergency Medicine*, 25(11), 1194-1203. <https://doi.org/10.1111/acem.13497>

- Kuhnert, K. W., & Lewis, P. (1987). Transactional and transformational leadership: A constructive/developmental analysis. *Academy of Management Review*, 12(4), 648-657. <https://doi.org/10.2307/258070>.
- Lederer, L., & Wetzel, C. A. (2014). The health consequences of sex trafficking and their implications for identifying victims in health care facilities. *Annals of Health Law*, 23(1), 61-91. Retrieved from <https://www.icmec.org/wp-content/uploads/2015/10/Health-Consequences-of-Sex-Trafficking-and-Implications-for-Identifying-Victims-Lederer.pdf>.
- Lewin, K. (1951). *Field theory of social science: Selected theoretical papers*. D. Cartwright (Ed.). New York, NY: Harper and Row.
- Lopez, B. (2019). Social ROI. In Institute for Inclusion in the Legal Profession. *Is ROI the appropriate measure for D&I?* Retrieved from <http://www.theiilp.com/resources/Documents/ROI%20Report%20FINAL.pdf>
- Martinelli, R. J., & Milosevic, D. Z. (2016). *Project management toolbox*. (2nd ed.). Hoboken, NJ: John Wiley & Sons.
- Melnyk, B. M., Gallagher-Ford, L., & Fineout-Overhold, E. (2017). *Implementing the evidence-based practice competencies in healthcare*. Indianapolis, IN: Sigma Theta Tau International.
- Menschner, C., & Maul, A. (2016). Issue brief: Key ingredients for successful trauma-informed care implementation. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf.
- Microsoft Corporation. (2019). Excel. Retrieved from <https://products.office.com/en-us/excel>

- Minemyer, P. (2017, March 16). Dignity Health leads fight against human trafficking, offers coordinated approach to identify, approach victims. *Fierce Healthcare*. Retrieved from <https://www.fiercehealthcare.com/healthcare/dignity-health-releases-guidelines-to-help-providers-identify-support-victims-human>
- Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009, July 21). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Med*, 6(7), e1000097. <https://doi.org/10.1371/journal.pmed1000097>
- Mostajabian, S., Santa Maria, D., Wiemann, C., Newlin, E., & Bocchini, C. (2019). Identifying sexual and h exploitation among sheltered youth experiencing homelessness: A comparison of screening methods. *International Journal of Environmental Research and Public Health*, 16(363), 1-16. <https://doi.org/10.3390/ijerph16030363>
- Mumma, B. E., Scofield, M. E., Mendoza, L. P., Toofan, Y., Youngyunpipatkul, J., & Hernandez, B. (2017). Screening for victims of sex trafficking in the emergency department: A pilot program. *Western Journal of Emergency Medicine*, 18(4), 616-620. <https://doi.org/10.5811/westjem.2017.2.31924>
- National Center for Missing and Exploited Children. (2019). Child sex trafficking. Retrieved from <http://www.missingkids.com/theissues/trafficking>
- National Research Council. (2014). *Confronting commercial sexual exploitation and sex trafficking of minors in the United States: A guide for the health care sector*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/18886>
- National Human Trafficking Hotline. (2019). Hotline statistics. Retrieved from <https://humantraffickinghotline.org/states>

- Polaris. (2011). Comprehensive human trafficking assessment tool. Retrieved from <https://humantraffickinghotline.org/resources/comprehensive-human-trafficking-assessment-tool>
- Polaris. (2018). On-ramps, intersections, and exit routes: A roadmap for systems and industries to prevent and disrupt human trafficking. Retrieved from <https://polarisproject.org/a-roadmap-for-systems-and-industries-to-prevent-and-disrupt-human-trafficking>
- Polaris. (2019). 2018 statistics from the national human trafficking hotline. Retrieved from https://polarisproject.org/sites/default/files/Polaris_National_Hotline_2018_Statistics_Fact_Sheet.pdf.
- Simich, L., Goyen, L., Powell, A., & Mallozzi, K. (2014). Final report: Improving human trafficking victim identification – validation and dissemination of a screening tool. *National Institute of Justice*, Award No.: 2011-MU-MU-0066. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/246712.pdf>
- Smith, L., Vardaman, S., & Snow, M. (2009). *The national report on domestic minor sex trafficking: America's prostituted children*. Vancouver, WA: Shared Hope International.
- State of Arizona. (2020, March 11). COVID-19: Declaration of emergency, executive order. Office of the Governor Doug Ducey. Retrieved from <https://azgovernor.gov/governor/news/2020/03/covid-19-declaration-emergency-executive-order>

State of California. (2020, March 04). Governor Newsom declares state of emergency to help state prepare for broader spread of COVID-19. Office of the Governor Gavin Newsom. Retrieved from <https://www.gov.ca.gov/2020/03/04/governor-newsom-declares-state-of-emergency-to-help-state-prepare-for-broader-spread-of-covid-19/>

State of Nevada. (2020, March 12). Declaration of emergency for COVID-19. State of Nevada Executive Department, Nevada Governor Steve Sisolak. Retrieved from https://gov.nv.gov/News/Emergency_Orders/2020/2020-03-12_-_COVID-19_Declaration_of_Emergency/

Substance Abuse and Mental Health Services Administration. (2014). Tip 57 – A treatment improvement protocol. Trauma informed care in behavioral health services. HHS Publication No. (SMA) 14-4816. Retrieved from https://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf.

Trafficking Victims Protection Reauthorization Act of 2003, Pub. L. No. 108-193, 117 Stat. 2875. (2003). Retrieved from <https://www.congress.gov/108/plaws/publ193/PLAW-108publ193.pdf>.

Trafficking Victims Protection Reauthorization Act of 2005, Pub. L. No. 109-164, 119 Stat. 3558 (2006). Retrieved from <https://www.congress.gov/109/plaws/publ164/PLAW-109publ164.pdf>.

Trafficking Victims Protection Reauthorization Act of 2013, Pub. L. No. 110-457, 127 Stat. 54. (2013). Retrieved from <https://www.govinfo.gov/content/pkg/PLAW-113publ4/pdf/PLAW-113publ4.pdf>.

- Tyson, B. (2010). *Havelock's theory of change*. Retrieved from <http://www.brighthubpm.com/change-management/86803-havelocks-theory-of-change/>
- United Nations. (n.d.). Human trafficking FAQs. Office on Drugs and Crime. Retrieved from <https://www.unodc.org/unodc/en/human-trafficking/faqs.html>
- United Nations. (2020). Impact of the COVID-19 pandemic on trafficking in persons. Office on Drugs and Crime. Retrieved from https://www.unodc.org/documents/Advocacy-Section/HTMSS_Thematic_Brief_on_COVID-19.pdf
- United States Department of Justice. (n.d.). Human trafficking. Retrieved from <https://www.justice.gov/humantrafficking>
- United States Government Publishing Office. (2000). H.R. 3244. Victims of Trafficking and Violence Protection Act of 2000. Retrieved from <https://www.govinfo.gov/content/pkg/BILLS-106hr3244enr/pdf/BILLS-106hr3244enr.pdf>
- University of San Francisco. (2019). About-USF. Retrieved from <https://www.usfca.edu/about-usf/who-we-are/vision-mission>
- Varma, S., Gillespie, S., McCracken, C., & Greenbaum, V. J. (2015). Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse and Neglect*, 44, 98-105.
<https://doi.org//10.1016/j.chiabu.2015.04.004>

- VERA Institute of Justice. (2014). Screening for human trafficking. Guidelines for administering the trafficking victim identification tool (TVIT). Retrieved from <https://www.vera.org/downloads/publications/human-trafficking-identification-tool-and-user-guidelines.pdf>
- Violence Against Women Reauthorization Act of 2013, Pub. L. No. 113-4, 127 Stat. 54. (2013). Retrieved from <https://www.congress.gov/113/plaws/publ4/PLAW-113publ4.pdf>.
- Waxman, K.T. (Ed.). (2018). *Financial and business management for the Doctor of Nursing Practice* (2nd ed.). New York, NY: Springer Publishing.
- Wiedenbach, E. (1963). The helping art of nursing. *American Journal of Nursing*, 63(11), 54-57. Retrieved from https://journals.lww.com/ajnonline/Abstract/1963/63110/THE_HELPING_ART_OF_NURSING.7.aspx
- Weiss, K. W. (2015). Steps to safety: A guide to drafting Safe Harbor legislation to protect sex-trafficked children. End Child Prostitution and Trafficking (ECPAT) USA. Retrieved from https://static1.squarespace.com/static/594970e91b631b3571be12e2/t/5977af9a2e69cfa18f34c54/1501015971553/ECPAT-USA_StepsToSafety.pdf
- William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008, Pub. L. No. 110-457, 122 Stat. 5044 (2008). Retrieved from <https://www.congress.gov/110/plaws/publ457/PLAW-110publ457.pdf>
- Williams, P. R., Wyatt, W., & Gaddis, A. (2018). Identification of client involvement in sex trafficking in Mississippi. *Journal of Evidence-Informed Social Work*, 15(2), 170-185. <https://doi.org/10.1080/23761407.2018.1430645>

World Health Organization. (2020a, January 30). Statement on the second meeting of the International Health Regulations (2005) emergency committee regarding the outbreak of the novel coronavirus (2019-nCoV). Retrieved from [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-nCov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-nCov))

World Health Organization. (2020b, July 31). Rolling updates on coronavirus disease (COVID-19). Retrieved from <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen>

Section IX: Appendices*Appendix A. List of Dignity Health acute care hospitals*

FACILITY	CITY	STATE
Arizona General Hospital - Laveen	Laveen	AZ
Arizona General Hospital - Mesa	Mesa	AZ
Arroyo Grande Community Hospital	Arroyo Grande	CA
Bakersfield Memorial Hospital	Bakersfield	CA
California Hospital Medical Center	Los Angeles	CA
Chandler Regional Medical Center	Chandler	AZ
Community Hospital of San Bernardino	San Bernardino	CA
Dominican Hospital	Santa Cruz	CA
French Hospital Medical Center	San Luis Obispo	CA
Glendale Memorial Hospital	Glendale	CA
Marian Regional Medical Center	Santa Maria	CA
Mark Twain Medical Center	San Andreas	CA
Mercy General Hospital	Sacramento	CA
Mercy Gilbert Medical Center	Gilbert	AZ
Mercy Hospital Bakersfield	Bakersfield	CA
Mercy Hospital Folsom	Folsom	CA
Mercy Medical Center Merced	Merced	CA
Mercy Medical Center Mt. Shasta	Mt. Shasta	CA
Mercy Medical Center Redding	Redding	CA
Mercy San Juan Medical Center	Carmichael	CA
Mercy Southwest Hospital	Bakersfield	CA
Methodist Hospital	Sacramento	CA
Northridge Hospital Medical Center	Northridge	CA
Sequoia Hospital	Redwood City	CA
Sierra Nevada Memorial Hospitals	Grass Valley	CA
St. Bernardine Medical Center	San Bernardino	CA
St. Elizabeth Community Hospital	Red Bluff	CA
St. Francis Memorial Hospital	San Francisco	CA
St. John's Pleasant Valley Hospital	Camarillo	CA
St. John's Regional Medical Center	Oxnard	CA
St. Joseph Hospital Medical Center	Phoenix	AZ
St. Joseph Hospital Medical Center - Westgate	Phoenix	AZ
St. Joseph Medical Center	Stockton	CA
St. Mary Medical Center	Long Beach	CA
St. Mary's Medical Center	San Francisco	CA
St. Rose Dominican - Rose Delima Campus	Henderson	NV
St. Rose Dominican - San Martin Campus	Las Vegas	NV
St. Rose Dominican - Siena Campus	Henderson	NV
University of AZ Cancer Center at St. Joseph Hospital Medical Center	Phoenix	AZ
Woodland Healthcare	Woodland	CA

Note: List of Dignity Health acute care hospitals as of December 2019.

Appendix B. Literature search strategy: PRISMA diagram

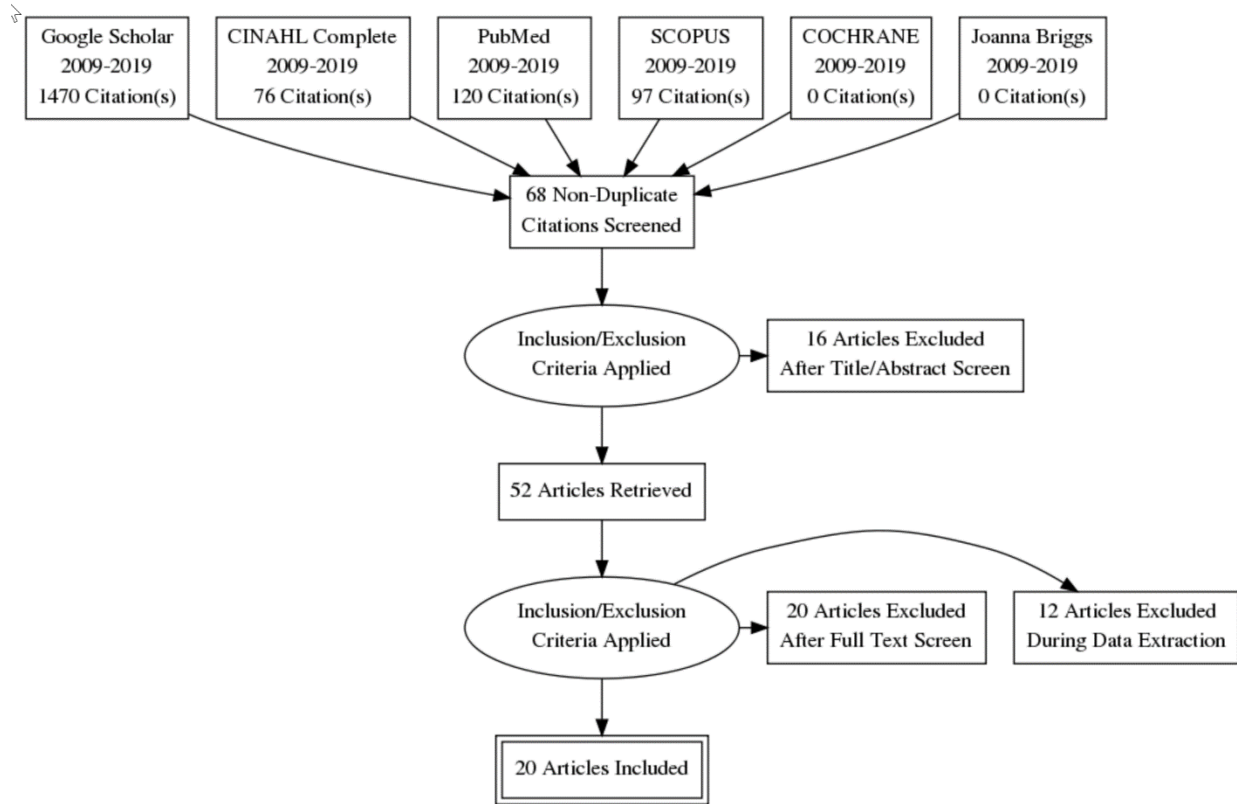


Figure 1. PRISMA Flow diagram adapted from Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009, July 21). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Med*, 6(7), e1000097. <https://doi.org/10.1371/journal.pmed1000097>

Appendix C. Evidence table

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Armstrong, S. (2017). Instruments to identify commercially sexually exploited children: Feasibility of use in the emergency department setting. <i>Pediatric Emergency Care</i>, 33(12), 794-799. doi: 10.1097/PEC.0000000000001020</p>	<p>Examines screening instruments that are used today to identify sexually exploited children for the feasibility of using them in the ED</p>	<ul style="list-style-type: none"> • Integrative review, non-experimental • No specific theory or conceptual framework reported 	<ul style="list-style-type: none"> • CINAHL, Scopus, PubMed, and EBSCOhost were searched. • January 6 and February 14, 2016 • Six relevant screening tools were identified. • Inclusion criteria: any instrument that screened only for sexual exploitation of children <= 18 years of age and that could be used in a healthcare facility • 1,436 articles, 24 selected for full-text review; six were eligible for inclusion in the review 	<ul style="list-style-type: none"> • Instruments meeting inclusion criteria were evaluated for the number of questions, scoring methods, population targeted, and training information. • The Oxford Centre for Evidence-based medicine Level of Evidence (2009) was used for evaluation. 	<ul style="list-style-type: none"> • All six of the instruments were developed within the past six years. • The number of questions ranged from six to 97. • Only one instrument relied on self-reporting; the others included observations, medical record reviews, or reports by others (or self). • Only two instruments reported validity measurements. 	<ul style="list-style-type: none"> • Very few screening tools exist to identify child commercial sex trafficking. • Only two instruments were recommended for use in the ED based on administration ease and the low number of questions. • Limitation: The study did not include instruments that screened for both sex and labor trafficking; it only included academic publishing. • Conclusions: There is a paucity of human trafficking screening tools 	<p>Level: V Quality: C</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Armstrong, S., Greenbaum, V. J., López, C., & Barroso, J. (2019). Preparedness to identify and care for trafficked persons in South Carolina hospitals: A state-wide exploration. <i>Journal of Human Trafficking</i>, 1-28. doi: 10.1080/23322705.2019.1603747</p>	<p>To determine the level of preparedness of hospitals throughout South Carolina (SC) for the identification and care of victims of human trafficking</p>	<ul style="list-style-type: none"> • Qualitative descriptive study using stratified purposive sampling • Highly structured interviews were conducted. • Common Ground Preparedness Framework used 	<ul style="list-style-type: none"> • IRB-exempt • Telephone interviews were conducted with the Emergency Department (ED) managers and directors between January-February 2018. • Urban, suburban, and rural hospitals from all four regions of the state of South Carolina were included (n=18) • The National Human Trafficking Hotline 2016 	<ul style="list-style-type: none"> • Highly structured telephone interviews – not recorded • Electronic interview form created in Excel and used for each interview • Fourteen questions were asked. • Responses and field notes were documented; questions were asked in the same order at each interview. • Interviews averaged 30 minutes in length. 	<ul style="list-style-type: none"> • Eighteen hospitals were included • Respondents were primarily female (83%), with 28% between the ages of 35-44 years • 72.2% believe HT occurs in their area, but 77.8% reported they had not cared for an HT victim • Factors to help identify victims included (1) information provided by the patient, (2) nurse felt “something was not right,” (3) patient did 	<p>available for pre-adolescents. Two have been identified for the feasibility of use in the ED based on the ease of administration, simple format, and brevity.</p> <ul style="list-style-type: none"> • Nurses with the Sexual Assault Nurse Examiner certification were the most knowledgeable. • Clinicians recognized “something was not quite right” but could not move from suspicion to confirmation. • Limitations included small sample size, data collection during the influenza epidemic, and homogeneity of the participants’ roles and responsibilities. 	<p>Level: III Quality: B</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
			<p>SC state report was used to understand when trafficking indicators had been documented.</p> <ul style="list-style-type: none"> Hospitals were selected if they had EDs in a geographic location where trafficking indicators had been reported to the NHTRC in 2016. Substance abuse, rehabilitation, behavioral health, and veterans' hospitals were excluded. 		<p>not have identification (ID), (4) patient was school-aged but not in school during the daytime hours and had low cognitive function</p> <ul style="list-style-type: none"> Hospitals did not have formal policies related to human trafficking (83.3%), and 83.3% said their hospitals had not prepared them to care for trafficked patients. 	<ul style="list-style-type: none"> Conclusion: Hospitals in SC are underprepared to identify and care for persons who are trafficked. Future research needs to look at how other states compare for trends and patterns of consistency. There were variances in response protocols, implementation procedures, and training effectiveness. Need to understand the service needs of HT survivors better. 	

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Baldwin, S. B., Eisenman, D. P., Sayles, J. N., Ryan, G., & Chuang, K. S. (2011). Identification of human trafficking victims in health care settings. <i>Health and Human Rights, 13</i>(1), 36-49.</p>	<p>To characterize encounters by trafficking victims in healthcare settings in the United States (US)</p>	<ul style="list-style-type: none"> • Qualitative descriptive study • Semi-structured interviews – face-to-face • Framework analysis approach • Principal Investigator (PI) conducted all interviews • June 2006 to April 2008 	<ul style="list-style-type: none"> • Phase I: a convenience sample of six key informants who work closely with trafficking victims. Results from this phase informed Phase II • Phase II: Twelve female survivors of trafficking were recruited with the assistance of the Coalition to Abolish Slavery & Trafficking (CAST). • Survivors were recruited through a non-governmental organization (NGO) in Los Angeles (LA); all were trafficked in LA. • Interviews were 	<ul style="list-style-type: none"> • All interviews were conducted in private, audio-taped, and transcribed professionally. • Recruitment and informed consent materials were translated into six different languages • Major themes were identified, and line by line review of the transcribed interviews was performed. • Half of the victims were seen by a health care provider while being trafficked, and the most common reasons included pregnancy tests, sexually transmitted infections, and abortions. 	<ul style="list-style-type: none"> • Survivors came from ten countries – domestic servitude (n=8), sex trafficking (n=2), and one had experienced both. • Periods of captivity: several weeks to seven years • Ages ranged from 22 to 63 years • Half (50%) had visited a health care provider while under control of their trafficker. • Visits were related to respiratory or systemic illness, injury, dental treatment, or treatment of HIV or STIs, pregnancy tests, and abortions. • Communication with health care workers was stifled or 	<ul style="list-style-type: none"> • Recommended attempting to interview victims in private, and (b) when taking a history, include questions about social history, home and work environment, and more nuanced questions about the presenting chief complaint. • Limitations include small sample size, and survivors were recruited from only one agency in one city. 	<p>Level: III Quality: B</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
			<p>conducted in English, using professional interpreters, in six other languages</p>		<p>prevented due to proximity and control of the trafficker; even when in private, fear and shame and feelings of helplessness and hopelessness prevented disclosure.</p> <ul style="list-style-type: none"> • In two cases, the physician was a relative of the trafficker. • None were identified as victims of trafficking by health care workers. • All twelve participants escaped their trafficking by taking their actions, law enforcement intervention, or assistance from acquaintances. • Victims present with a variety of complaints; there is no typical patient victim. 		

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					<ul style="list-style-type: none"> • Survivors stated their body language and affect may convey their victim status. • Certain behaviors by the victim and the trafficker may signal further inquiry by the health care provider. • Language barriers and social and cultural alienation are problematic. • Clinicians may miss important signs due to lack of training, lack of awareness, lack of time, and personal bias. 		

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Bespalova, N., Morgan, J., & Coverdale, J. (2016). A pathway to freedom: An evaluation of screening tools for the identification of trafficking victims. <i>Academy of Psychiatry, 40</i>, 124-128. doi:10.1007/s40596-014-0245-1</p>	<p>Review existing assessment tools related to human trafficking to aid physicians in screening for potential victims</p>	<ul style="list-style-type: none"> • PubMed and Google literature search • Literature review for existing screening tools with a structured framework • Applicable to the health care system in the U.S. • No specific theory or conceptual framework reported 	<ul style="list-style-type: none"> • The search yielded 15 screening tools for the identification of human trafficking victims • Qualitative review • May 15 to July 5, 2014 	<p>Each tool was described based on (1) the setting in which it applied, (2) the format, (3) whether the tool's psychometric properties had been assessed, (4) the date of the last update, (5) whether follow up information was provided to identified victims, and (6) whether the tool contained information on legal issues.</p>	<ul style="list-style-type: none"> • Fifteen tools were identified, nine met inclusion criteria. • Six tools were eliminated: (1) designed for law enforcement (n=3), lacked original questions (n=2), and lacked interview component (n=1) • Target populations varied – four focused on screening adults, and one specifically focused on children. • Only two were specifically designed for health care. • The number of questions varied (range: 3-100); four surveys contained ten questions • Formats varied 	<p>Limitations:</p> <ul style="list-style-type: none"> • Only two databases used • Used limited search terms • Most of the information is not available through academic institutions but rather through legal sources and non-profit organizations <p>Strengths:</p> <ul style="list-style-type: none"> • Identified some of the most commonly available human trafficking screening tools available in the US 	<p>Level: V Quality: B</p>

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					<ul style="list-style-type: none"> • Little consensus on content among the nine tools • Only one tool (Polaris Project Medical Assessment Tool) had been assessed for validity and reliability, but not in a health care setting. 		
<p>Chang, K. S. G., Lee, K., Park, T., Sy, E., & Quach, T. (2015). Using a clinic-based screening tool for primary care providers to identify commercially sexually exploited children. <i>Journal of Applied Research on Children</i>, 6(1), Article 6. Retrieved from http://digitalcommons.library.tmc.edu/childrenatrisk/</p>	<p>To determine the proportion of Asian Health Services (AHS) teen clinic patients screened for commercially sexually exploited children (CSEC). Based on the use of a screening protocol, it can be used to detect and connect patients with support and services</p>	<ul style="list-style-type: none"> • Retrospective cohort design • Retrospective chart abstraction performed • No specific theory or conceptual framework reported 	<ul style="list-style-type: none"> • Patients identified between 2008 – 2011 who received services at the Asian Health Services clinical setting • Approved by Institutional Review Board (IRB) • N = 626 eligible for the study, n = 621 charts reviewed • Females aged 13 to 23 years 	<ul style="list-style-type: none"> • Abstraction manual created • Abstractors were trained; a secondary review was performed • Chart abstractions were performed by four trained staff and conducted between September 2011 and February 2014 • Data collected included demographics, home 	<ul style="list-style-type: none"> • Descriptive statistics used for demographics, prevalence of CSEC, and distribution of risk factors data • Univariate logistic regression – tested different explanatory variables that predict CSEC victimization • Also tested multivariate logistic regression – limited by small sample size 	<ul style="list-style-type: none"> • Strength: IRB approval obtained • Limitations include underscreening and underreporting of CSEC by teen patients • Had a much larger proportion of patients not screened for CSEC but had risk factors – highlighting the importance of universal CSEC screening 	<p>Level: III Quality: B</p>

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			<ul style="list-style-type: none"> • Received sexual and reproductive health services • Excluded clinic visits solely for birth control or prenatal care; males were excluded 	<p>environment and safety, school enrollment and performance, sexuality and birth control, history of CSEC, and patterns of clinical testing requests</p>	<ul style="list-style-type: none"> • More than 50% of participants Asian, 22% African American, 7.6% Hispanic • Of the 621 charts screened for abstraction, 177 were screened for CSEC, of which 13 (7.3%) confirmed having experienced CSE • Those with STI history were seven times more likely to have experienced sexual exploitation than those without an STI history. • Those with more than two sexual partners at the time of screening were 15 times more likely to have been exploited sexually than those with less than two sexual partners. 	<ul style="list-style-type: none"> • Low CSEC screening due to lack of provider awareness • Retrospective review was based on documentation in the chart – the data may be incomplete or inconsistent • Screening protocol applied to patients ages 11-18, yet the screening included patients up to the age of 23 • The study only included females • Clinic-based settings and providers can play an important role in identifying CSEC victims and redirecting or preventing revictimization. 	

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					<ul style="list-style-type: none"> • Those with a history of > 10-lifetime sexual partners were 19 times more likely, and patients with two or more risk factors were six times more like to have experienced sexual exploitation. 		
<p>Chisolm-Straker, M., Baldwin, S., Gaigbe-Togbe, B., Ndukwe, N., Johnson, P. N., & Richardson, L. D. (2016). Health care and human trafficking: We are seeing the unseen. <i>Journal of Health Care for the Poor and Underserved</i>, 27(3), 1220-1233. doi:10.1353/hpu.2016.0131</p>	<p>To contribute to the larger body of knowledge about whether victims of human trafficking access health care and to identify the health care settings most frequently used by victims</p>	<ul style="list-style-type: none"> • Anonymous, retrospective, quantitative study • Online and paper survey available in three languages (English, Spanish, and Haitian Creole) • IRB approved • No identifying information collected • Verbal and written consent waived to protect anonymity 	<ul style="list-style-type: none"> • Human Trafficking (HT) survivors residing in the US • All ages, all genders • Anti-trafficking organization (ATO) invited to participate (N=24) • Paper surveys were distributed through the ATOs. • Online surveys 	<ul style="list-style-type: none"> • Questionnaire – online and paper – developed based on a previous qualitative study (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011) and then revised based on feedback. • All surveys included (1) Demographics, (2) US versus non-US born, (3) medical illnesses, (4) health care 	<ul style="list-style-type: none"> • N=173 respondents • Surveys completed in paper form (43%) and online (57%) • Ninety-four percent completed the survey in English, six percent in Spanish • Chi-square used for categorical data; <i>t</i>-test used for continuous variables • Survivors reported being 	<ul style="list-style-type: none"> • This was the largest study of its kind to date. • The sample size is small compared to the number of trafficking victims. • There is limited ability to generalize the findings. • Due to the retrospective methodology, it is susceptible to recall bias. • A gift card incentive may have attracted non-victims to 	<p>Level: III Quality: B</p>

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		<ul style="list-style-type: none"> No specific theory or conceptual framework reported 	<p>advertised on Facebook, advocate-survivor blog and ATOs websites and in their offices</p> <ul style="list-style-type: none"> May 2012 – December 2013 Respondents to the paper survey were identified as HT survivors through experts and advocates at the ATOs Respondents to the online survey self-identified as HT survivors Respondents who answered “no” to the question “Are you a survivor of slavery, or were you made to work or made to do 	<p>desired and received, (5) type of health care provider seen, and (6) whether correctly identified as a victim of HT and offered assistance</p>	<p>trafficked in 38 states in the US.</p> <ul style="list-style-type: none"> For paper survey responses: The mean age of escape was 31 years; for online survey responses, the mean age of escape was 26 years. Significantly more males responded using the online survey ($p < .001$), non-US born ($p < .001$), and more educated ($p < .001$), Significantly more females < 18 years old were trafficked ($p < .001$) as compared to males (23 years), and a significantly smaller portion of females graduated from high school ($p < .001$), Most female survivors were 	<p>respond, potentially skewing the data.</p> <ul style="list-style-type: none"> The survey was difficult and time-consuming for poorly literate participants. Only English and Spanish versions of the survey were returned; it may be difficult to generalize beyond those who read/write these languages. 	

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			sexual acts?" were excluded		<p>trafficked for commercial sex ($p < .001$) while males were labor trafficked ($p < .001$)</p> <ul style="list-style-type: none"> • Seventy-three percent of survivors wanted to see a health care provider (HCP), and 68% were seen. No correlation between birth location or gender and the ability to see HCP. • Thirty-one percent of those unable to see an HCP were prevented by someone from doing so. • 66% reported physical abuse as the most reported reason for seeking care, followed closely by self-reported depression at 65%. 		

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					<ul style="list-style-type: none"> • For those who spoke to an HCP about their trafficking, 72% were offered information on rescue/how to escape. • For those seen by an HCP, 56% were seen by emergency and urgent care providers, 44.4% by Primary Care Physicians (PCP), and 25.6% by obstetric/gynecologists. • Specific screening questions seemed to improve victim identification; for victims identified, there was a statistically higher frequency of six of the eight questions being asked ($p < .001$) • Ninety percent of victims who were identified 		

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					<p>were questioned about their work and living situation.</p> <ul style="list-style-type: none"> • Most identified victims reported a missed opportunity for a life-changing intervention more than half the time (56%). • Victims are not consistently identified 		
<p>Chisolm-Straker, M., Sze, J., Einbond, J., White, J., & Stoklosa, H. (2019). Screening for human trafficking among homeless young adults. <i>Children and Youth Services Review, 98</i>, 72-29. doi:10.1016/j.childyouth.2018.12.014</p>	<p>To develop a user-friendly, brief yet sensitive human trafficking (HT) screening tool for homeless young adults</p>	<ul style="list-style-type: none"> • Prospective cohort study • Screening tool development and validation • Multi-objective study examining homeless youth, their experience with trafficking, and outcomes • Two-step process: Step one asked candidate screening questions 	<ul style="list-style-type: none"> • Young adult clients of Covenant House of New Jersey, ages 18 – 22 years eligible for participation • 15 months period from November 2, 2015 – February 21, 2017 • An information sheet was provided to each participant. 	<ul style="list-style-type: none"> • Vera Institute of Justice Trafficking Victims Identification Tool (2014, pp. 13-25) • Human Trafficking Interview and Assessment Measure (HTMIA-14) (Bigelsen & Vuotto, 2013) used in Step two of the study 	<ul style="list-style-type: none"> • Assessments completed (n=340) • Participants (n=307) • Multivariate logistic model run on the five candidate questions • Descriptive statistics for demographic variables • Chi-square test of independence • Sensitivity, specificity, positive and negative predictive values 	<ul style="list-style-type: none"> • The Quick Youth Indicators for Trafficking (QYIT) is highly sensitive and does not require a trafficking expert to administer. • QYIT may not be as sensitive to adult victims. • The study population was primarily comprised of non-White young adults. 	<p>Level: II Quality: B</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
		<p>within the first three days of the stay at Covenant House of New Jersey (CHNJ); Step two conducted in the first 14 days of the participants' stay at CHNJ.</p> <ul style="list-style-type: none"> No specific theory or conceptual framework reported 	<ul style="list-style-type: none"> Written consent was waived to protect anonymity. Only those who consented to submitting their de-identified information were included in the study. Efforts to Outcomes (ETO) (Social Solutions, 2019) platform was used for data collection. 		<ul style="list-style-type: none"> Less than 20% identified as white, the average age was 19.5 years Of the 340 participants, 8.8% (n = 30) experienced trafficking. Those who experienced trafficking: 69% sex trafficking, 48.3% labor trafficking, and 17.2% both sex and labor trafficking The QYIT tool was 86.7% sensitive and 76.5% specific in identifying a trafficked individual when at least one question was answered in the affirmative Those who had a trafficking experience had a statistically significant difference in the 	<ul style="list-style-type: none"> May not be able to generalize findings to other settings, age groups, or among a mostly white population QYIT may not be as sensitive for young adults who do not access social services. 	

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
					need for parenting classes ($p < .02$) and psychological support ($p < .01$) • Labor trafficking is a major form of trafficking in the homeless young adult population		
Dank, M., Yahner, J., Yu, L., Vasquez-Noriega, C., Gelatt, J., & Pergamit, M. (2017). Pretesting a human trafficking screening tool in the child welfare and runaway and homeless youth systems. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/93596/pretesting_tool_1.pdf	Development and pretesting of a Human Trafficking Screening Tool (HTST) for youth in the child welfare and runaway and homeless youth systems	<ul style="list-style-type: none"> • Prospective cohort study • Conducted a comprehensive review of current screening tools and protocols • Developed, programmed, and tested a 19 item survey (HTST) by selecting relevant questions from existing tools; captured demographics and trafficking experiences • A full version of the HTST took two 	<ul style="list-style-type: none"> • N = 617 • Ages 12 to 24 years • NY, TX, and WI • March to November 2016 	<ul style="list-style-type: none"> • Survey tool categories included: (1) emotional, (2) physical and relationship abuse, (3) appearance, (4) demographics, (5) family background, (6) experience with the child welfare system, (7) criminal history, (8) mental and emotional health, (9) physical health, (10) sexual behavior, (11) runaway/homeless experience, 	<ul style="list-style-type: none"> • The HTST is easy to administer. • Both the longer version (19 questions) and the abbreviated version (HTST-SF) (six questions) are effective in identifying victims of HT. • The HTST short version performed as well as the full version and both correctly predicted HT – 6 in 10 times for HT victims and 8 in 10 times for nonvictims. 	<ul style="list-style-type: none"> • There is currently no consensus on how to effectively screen for HT. • It is unclear whether the tools currently used could effectively identify victims with diverse backgrounds, needs, ages, etc. • Service providers lack the training to identify and address the needs of trafficked youth. • Suggest retesting the 	Level: II Quality: B

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
		minutes to complete • The shorter version (HTST-SF) took less than one minute to complete • IRB approvals obtained • Anonymous, self-administered electronic format • Random 25% administered the survey by a practitioner • Six research questions were presented • Purposive sample used for pretest (N=617) • No specific theory or conceptual framework reported		(12) migration and immigration experience, (13) living conditions, (14) sexual exploitation, abuse, and evidence of trafficking, recruitment experience. • Survey piloted in two sites in Washington DC to test the feasibility of administration and face validity.		HTST's validity, sensitivity, and specificity for youth under age 18 because the sample sizes did not meet the minimum numbers required. • Due to the purposive nature of sampling, cannot generalize results	

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Dols, J. D., Beckmann-Mendez, D., McDow, J., Walker, K., & Moon, M. D. (2019). Human trafficking victim identification, assessment, and intervention strategies in south Texas emergency departments. <i>Journal of Emergency Nursing, 45</i>(6), 622-633. doi:10.1016/j.jen.2019.07.002</p>	<p>To identify current practice in Emergency Departments (ED) used to identify, assess, and provide interventions for victims of human trafficking (HT)</p>	<ul style="list-style-type: none"> • Descriptive design • Cross-sectional study • Twenty-three question survey • Institutional Review Board (IRB) approval was obtained • Voluntary participation • No specific theory or conceptual framework reported • Survey design 	<ul style="list-style-type: none"> • ED leaders in 47 south Texas counties; 44.7% (n=21) were border counties near the Rio Grande river • Population of this area: 5,103,477 • Twenty-seven ED leaders responded • EDs in 21 counties; 22 trauma service areas 	<ul style="list-style-type: none"> • Sequential surveys: online, email, or phone 	<ul style="list-style-type: none"> • Response rate was 27.3% (n = 99); eleven (40.7%) screened adults and ten (37.0%) screened children for human trafficking. • Response rates were 56.5% online, 30.4% via email responses and 30.4% via phone. • Of the providers and staff who performed HT screening, physicians (37.0%), nurse practitioners (14.8%), physician assistants (14.8%), and registered nurses (66.7%) • None of the EDs identified a victim of HT in 2017. • Seventeen of the 27 EDs (63.0%) did not screen children for HT. 	<ul style="list-style-type: none"> • The study focused on a region in south Texas. • Convenience sample used • Low response rate • High turnover in ED leaders • Difficulties getting email and phone surveys to ED leaders • The survey was not designed to collect individual patient information. 	<p>Level: III Quality: C</p>

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					<ul style="list-style-type: none"> • Twenty-six (96.3%) of the EDs did not identify a child HT victim in 2017; one ED identified ten child victims. • Inconsistencies existed in ED screening and assessment processes to identify HT victims, the providers performing the screening, the location, timing of the screening, and staff and patient education. 		

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<p>Ertl, S., Bokor, B., Tuchman, L., Miller, E., Kappel, R., & Deye, K. (2019). Healthcare needs and utilization patterns of sex-trafficked youth: Missed opportunities at a children’s hospital. <i>Child Care Health Development</i>, 46, 422-427. doi:10.1111/cch.12759</p>	<p>To examine the healthcare needs and utilization patterns among domestic minor sex-trafficked (DMST) youth at an urban academic children’s medical center and to assess opportunities for earlier identification by determining if their risk factors are similar or unique to those previously published</p>	<ul style="list-style-type: none"> • Retrospective chart review • No specific theory or conceptual framework reported. 	<ul style="list-style-type: none"> • Children < 18 years old • Referred to child and adolescent protection center (CAPC) in an urban, academic children’s hospital in Washington, DC, for suspected or confirmed sex trafficking • January 1, 2006, to March 1, 2017 	<ul style="list-style-type: none"> • Descriptive analysis • Demographics and social, medical, and psychiatric histories were abstracted up to five years prior to their initial CAPC visit • N=191 encounters 	<ul style="list-style-type: none"> • Thirty-nine patients were identified. • Ninety percent of the patients were seen in the healthcare system within five years of their initial CAPC visit. This supports findings from previous studies. • Of the visits, 57% occurred in the ED. • The most common chief complaint was psychiatric related. • Less than half (43%) had documentation in the medical record by the provider for concerns about DMST despite displaying risk factors consistent with sex trafficking. 	<ul style="list-style-type: none"> • Small sample size • Limited to youth referred to CAPC • African American females were disproportionately represented in the sample, and males were under-represented in the study sample, therefore generalizability to other races, ethnicities, or genders. • Referrals to CAPC may represent a higher prevalence of certain risk factors not present in the general population. 	<p>Level: III Quality: C</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Goldberg, A. P., Moore, J. L., Houck, C., Kaplan, D. M., & Barron, C. E. (2017). Domestic minor sex trafficking patients: A retrospective analysis of medical presentation. <i>Pediatric Adolescent Gynecology</i>, 30, 109-115. doi:10.1016/j.jpag.2016.08.010</p>	<p>To improve identification and intervention for domestic minor sex trafficking (DMST)</p>	<ul style="list-style-type: none"> • Retrospective cohort study • Hospital Institutional Review Board approved • No specific theory or conceptual framework reported. 	<ul style="list-style-type: none"> • The Lawrence A. Aubin Senior Child Protection Center at Hasbro Children’s Hospital – Rhode Island • August 1, 2013 – March 30, 2015 • Ages less than 18 years • Referred for DMST evaluation secondary to sexual abuse • Self-disclosed histories of DMST or reported with evidence of being high risk for DMST • Retrospective medical record review (n = 41) • Medical records were reviewed by the primary and second author and 	<ul style="list-style-type: none"> • Variables included demographic, socio-environmental, medical, and psychiatric 	<ul style="list-style-type: none"> • Eighty-one percent are seen by a medical provider within one year of being referred for DMST evaluation. • Sexual abuse was identified in 57% of patients, 60 % had parental substance abuse, 32% had sexually transmitted infections, 20% had psychiatric needs, and 46% had previous psychiatric admission. • Sixty-eight percent currently lived at home, and 71% presented with a parent, guardian, or relative. • Ninety-five percent of the patients were female. • Mean age: 15.5 years 	<ul style="list-style-type: none"> • This study contributes to the list of clinical features of HT to aid clinicians in the identification of victims • Small sample size • Male DMST patients were under-represented • Generalizability to other settings limited • No causal factors can be linked to DMST due to the retrospective nature of this study. 	<p>Level: III Quality: B</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
			<p>trained research assistant.</p> <ul style="list-style-type: none"> The study included inpatient, outpatient, and emergency department (ED) encounters. 		<ul style="list-style-type: none"> Thirty-four percent are doing well in school; 37% had a history of truancy. Fifty-five percent of patients were confirmed DMST victims. Eighty-eight percent had a history of drug or alcohol abuse. Sixty-three percent had a history of being a runaway. Ninety percent were exposed to some form of maltreatment. Average of 3.46 medical visits within the year before their first referral for DMST. Suicidal ideation was found in 59% of patients. Twenty-one percent had at least one tattoo. Seventy-five percent of child 		

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
					<p>victims of HT had contact with a medical professional within the past six months, 80% within the past 12 months.</p> <ul style="list-style-type: none"> • Sixty-three percent presented to EDs and 25% to primary care areas. • Two most common chief complaints: mental health disorders and back and abdominal pain • Risk factors previously documented in the literature were consistent in this study. 		

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Greenbaum, V. J., Dodd, M., & McCracken, C. (2016). A short screening tool to identify victims of child sex trafficking in the health care setting. <i>Pediatric Emergency Care</i>, 34(1), 33-37. doi: 10.1097/PEC.0000000000000602</p>	<p>To develop a screening tool to identify potential victims of commercial sex trafficking among high-risk adolescent populations based on identified characteristics</p>	<ul style="list-style-type: none"> • Prospective cross-sectional study • All patients evaluated by a nurse practitioner or physician trained in trauma-informed care • Physical exam • Laboratory results • Medical record review • No specific theory or conceptual framework reported 	<ul style="list-style-type: none"> • Children ages 12 to 18 years suspected of child sex trafficking • June 1, 2013 – April 10, 2014 • Atlanta, GA • Three metropolitan pediatric emergency department • One child protection clinic • Exclusion criteria included extreme developmental delays, the appearance of intoxication, or inability to answer questions accurately 	<ul style="list-style-type: none"> • Suspected victims of child sex trafficking (CST) compared to youth in the same age group with alleged sexual abuse or sexual assault (ASA) without evidence of sex trafficking • Questions about history related to (1) medical, (2) substance use, (3) reproductive health, (4) high-risk behavior, (4) abuse/injury, and (5) mental health issues • Observations of initial presentation including demeanor, chief complaint, signs of intoxication, and information about person 	<ul style="list-style-type: none"> • Participants (N = 108) • Child sex trafficking (n = 25) • Child sexual abuse/assault (n = 83) • No statistical difference for age or gender; the average age of CST group 15.4 years, and 14.8 years in ASA group • Most patients are female: 100% and 98% in the CST and ASA groups, respectively • Race ($p = .005$) for African American and Other in the CST group • CST group more likely to have fractures or significant trauma ($p = .04$), history of sexual activity/violence with sex 	<ul style="list-style-type: none"> • The study contributes to existing evidence found in mixed populations of sex trafficking victims. • Only three males, all were in the ASA group • No international victims – limits generalizability of results • Sample size relatively small. • The study was conducted in a single pediatric health care facility in one city in the US. • Most CST victims were previously identified by law enforcement. • No actual knowledge of victimization; unclear 	<p>Level: III Quality: B</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
				accompanying child • Descriptive statistics • Statistical analysis: (1) Significance level at .05 (2) Mean and standard deviation (3) Two-sample <i>t</i> -test and (4) chi-square test (5) univariate analyses, (6) multivariate logistic regression (7) Wilcoxon rank-sum tests • Sensitivity, specificity, positive and negative predictive values for positive questions	($p = .32$), drug use ($p < .001$), encounters with law enforcement and child protective services (CPS) ($p < .001$), running away from home ($p < .001$), and a history of violence with others ($p < .001$) • More likely to have sexually transmitted infections (STI), history of pregnancy, and a longer history of sexual activity • Multivariate regression resulted in a six-question screening tool • Identified 16 factors (demographics, physical, historical, and behavioral) that differentiate CST	whether any of ASA victims were CST	

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
					from ASA children • Two positive answers on a six-item questionnaire had 92% sensitivity, 73% specificity, 51% positive predictive value (PPV), and 97% negative predictive value (NPV) for identifying CST		
Greenbaum, V. J., Livings, M. S., Lai, B. S., Edinburgh, L., Baikie, P., Grant, S. R., . . . Self-Brown, S. (2018). Evaluation of a tool to identify child sex trafficking victims in multiple healthcare settings. <i>Journal of Adolescent Health</i> , 63, 745-752. doi:10.16/j.jadohealth.2018.06.032	To evaluate a short screening tool to identify victims in a health care setting and to determine the prevalence of child sex trafficking (CST)	<ul style="list-style-type: none"> • Cross-sectional observational study • Self-reported questionnaires and examiner interviews • IRB approvals were obtained. • No specific theory or conceptual framework reported. 	<ul style="list-style-type: none"> • Sixteen sites in the United States (US) – all in urban areas (GA, MN, MO, TX, MI, OH, CO, NV, NY) • Five pediatric EDs • Six child advocacy centers • Five teen clinics • English speaking • Children between 11-17 years of age 	<ul style="list-style-type: none"> • Sixteen item screening tool • Inclusion criteria: acute sexual assault/abuse or concern for CST • Exclusion criteria: severe developmental delays, marked distress, intoxication, those who declined • Seventeen item questionnaire included information about high-risk 	<ul style="list-style-type: none"> • The overall prevalence of CST was 11.1%; 13.2% from ED and 16.4% from teen clinics • The screen had a sensitivity of 88.4%, a specificity of 57.5%, and a positive likelihood ratio of 1.99% • The negative predictive value was high • Ninety of the 810 (11.1%) participants were 	<ul style="list-style-type: none"> • Positive predictive value is low, and negative predictive value is high • Interventions prompted by a false positive screen may prevent an at-risk child from becoming a victim of HT. • Limitations included the fact that the study only included eight English speaking 	Level: III Quality: B

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
			<ul style="list-style-type: none"> • A chief complaint of sexual violence • N=810 participants; n=91 (11.5%) from ED; n=395 (48.8%) from child advocacy centers; n=324 (40.0%) from teen clinics • Data collected between May 1, 2015, and November 15, 2016 • Sites joined the study at different times • Minimum age criteria varied by site and ranged from 11-13 years; maximum age of 17 years 	<p>behaviors, law enforcement involvement, sexual history.</p> <ul style="list-style-type: none"> • Six question screening tool administered verbally • Two positive answers were considered a positive screen. • Descriptive statistics used • Screening tool sensitivity, specificity, and positive and negative predictive values 	<p>classified as victims of CST, with 13.2% of these found in the EDs</p> <ul style="list-style-type: none"> • Responses to the CST screen showed significant differences between CST and non-CST participants on each item. • Two hundred eighty-eight (40%) non-CST patients screened positive compared to 76 (84.4%) CST patients ($p < .001$). • A relatively large proportion of male participants (15.3%), accounting for 17% of identified victims in ED and 20% in child advocacy clinics • A high rate of CST in teen clinics was 	<p>patients, minimum age criteria varied, a true “gold standard” for victim identification is lacking; victims may have been reluctant to disclose their status or unable to recognize the exploitation.</p>	

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					<p>unexpected (16.4%).</p> <ul style="list-style-type: none"> • n = 100 screened positive with the tool (49%) • Eleven CST identified (5.4%) • Sensitivity 90.9% with a 95% CI [58.7%, 99.8%] • Specificity 53.1% with a 95% CI [45.6%, 60.4%] • Positive Predictive Value (PPV) 10% with a 95% CI [5.0%, 17.6%] • Negative Predictive Value (NPV) 99.0% with a 95% CI [94.7%, 99.9%] • The tool had high sensitivity and high NPV. Therefore, the tool can be used to rule out CST in the high-risk population 		

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Kaltiso, S. O., Greenbaum, V. J., Agarwal, M., McCracken, C., Zmitrovich, A., Harper, E., & Simon, H. K. (2018). Evaluation of a screening tool for child sex trafficking among patients with high-risk chief complaints in a pediatric emergency department. <i>Academic Emergency Medicine</i>, 25(11), 1194-1203.</p>	<p>To apply and evaluate a screening tool to identify child sex trafficking (CST) victims in pediatric emergency departments and to compare victims identified as CST to those who were not identified</p>	<ul style="list-style-type: none"> • Prospective, observational study • Representative convenience sampling • Institutional Review Board (IRB) approved • Waiver of parental consent • No specific theory or conceptual framework reported 	<ul style="list-style-type: none"> • July 2017 – November 2017 • Pediatric Emergency Department (PED) of inner-city children’s hospital in a major city in the southeastern area of the US with more than 60,000 visits/year • Representative sampling from all shifts, weekdays, and weekends • Patients ages 10 – 18 years, English speaking, males, and females • Chief complaints of high-risk sexual behaviors • Exclusion criteria included non- 	<ul style="list-style-type: none"> • The survey consisted of four parts: (1) history and demographics, (2) six-question screening tool, (3) additional screening questions for CST, and (4) conclusive questions to determine the status of CST • Descriptive statistics including mean, standard deviations, medians, and ranges • CST tool evaluated for sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) • Two sample <i>t-test</i> or Wilcoxon rank-sum tests 	<ul style="list-style-type: none"> • Two hundred and fifty-four met inclusion criteria • Forty-nine percent (n = 100) screened positive using the screening tool • Eight (72.7%) were newly identified victims • Five (45.5%) were detected only by the interviewer’s questions • Mean age of CST victim: 15.9 years (range: 13-19 years) • Females 81.5% (n = 9) • No specific chief complaint correlated with CST identification. • Forty-five percent of the CST victims had behavioral complaints and sexual issues accounted for 36%. 	<ul style="list-style-type: none"> • The study was performed using a convenience sample • Data were collected only when there was research present in the ED • A representative sample was collected for day, evening, and night shifts • Certain risk factors for CST were not studied, such as a history of sexual abuse or LBBTQ identification • Single study site • CST sample was small • Limited ability to generalize results due to small sample size 	<p>Level: III Quality: B</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
			<p>English speaking, acute medical emergencies, or intellectual disabilities</p> <ul style="list-style-type: none"> • Verbal assent obtained from patients in the presence of the accompanying individual • N = 254 met eligibility and inclusion criteria, n = 203 agreed to participate • All participants were given information about resources • Medical records reviewed to gather additional information • The sample size needed was estimated to be 220 with a recruitment goal of 250 	<p>for continuous variables</p> <ul style="list-style-type: none"> • Chi-square test for categorical variables • Fisher’s exact test used for small counts • Sensitivity analysis performed • Significance calculated at the .05 level 	<ul style="list-style-type: none"> • CST victims were more likely to be runaways ($p < .01$), history of drug/alcohol use ($p < .01$), more than five sexual partners ($p < .0001$), more than ten sexual partners ($p < .0001$) • Forty-five percent (n = 5) of the CST patients were identified solely by the secondary questions • All patients were offered social services • The screening tool demonstrated a Sensitivity of 90.9% with a 95% CI [58.7%, 99.8%] • Specificity 53.1% with a 95% CI [45.6%, 60,4%]; did not meet the proposed 		

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
					benchmark of 80% <ul style="list-style-type: none"> • Positive Predictive Value (PPV) 10.0% with a 95% CI [5.0%, 17.6%] • Negative Predictive Value (NPV) 99.0% with a 95% CI [94.7%, 99.9%] • A tool useful for excluding CST and identifying potential victims but not for confirmation of true CST victims 		
Lederer, L., & Wetzel, C. A. (2014). The health consequences of sex trafficking and their implications for identifying victims in health care facilities. <i>Annals of Health Law, 23</i> (1), 61-91.	To assess the health consequences and health experiences of women and girls exploited for commercial sex	<ul style="list-style-type: none"> • Mixed methods approach • Qualitative data collection from focus groups • Survey and structured interviews with quantitative analysis • No specific theory or conceptual framework reported 	<ul style="list-style-type: none"> • Female sex trafficking survivors • Single focus group used for a feasibility study in November 2011 • Eleven similar focused groups between January – December 2012 across the US 	<ul style="list-style-type: none"> • Health experiences and health conditions • Interviews included discussions regarding early trauma in childhood, age when first trafficked and how they were recruited, length of captivity, and health issues 	<ul style="list-style-type: none"> • 106 (99.1%) had at least one health problem while trafficked • Neurological conditions, nutritional disorders, and mental health issues were prevalent. • Top health problems: neurological, general health, injuries, cardiovascular, 	<ul style="list-style-type: none"> • Common symptoms and warning signs • Protocols for identifying victims aided in rescues • Training health care providers essential 	Level: III Quality: B

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
			<ul style="list-style-type: none"> • Focus groups (N=107), ages 14-60 years 	<ul style="list-style-type: none"> • Extensive health survey consisting of three components: (1) more than 100 discrete health conditions, including questions about violence, (2) open-ended questions about health care, and (3) symptoms experienced after escaping the exploitation 	respiratory, gastrointestinal, and dental <ul style="list-style-type: none"> • Mental health issues were the worst. • A majority (95.1%) experienced violence and abuse • Abortions and STIs not uncommon 		

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Mostajabian, S., Santa Maria, D., Wiemann, C., Newlin, E., & Bocchini, C. (2019). Identifying sexual and labor exploitation among sheltered youth experiencing homelessness: A comparison of screening methods. <i>International Journal of Environmental Research and Public Health</i>, 16(363), 1-16. doi:10.3390/ijerph16030363</p>	<p>To assess the difference between using a standard psychosocial assessment tool and an HT specific assessment tool in identifying the prevalence of sexual and labor trafficking as performed on youths experiencing homelessness; identify gaps in knowledge about HT available resources and barriers to disclosing and seeking help.</p>	<ul style="list-style-type: none"> • Quantitative dominant mixed-method study design including survey, focus group discussions, and retrospective medical record reviews • Three site study aimed at piloting a structured HT screening tool (HTST) • IRB approval • Self-administered and provider-administered survey • All surveys collected anonymously • Written informed consent was obtained from group participants • No specific theory or conceptual 	<ul style="list-style-type: none"> • HTST available in English and Spanish • One hundred twenty-one shelter residents consented to participate in screening study; medical records of 129 were reviewed • Participants randomly pre-assigned a 3:1 ratio based on birth month • Surveys completed within 30 minutes • Gift cards valued at \$25 were issued for completing the HTST • Home, Education, and Employment, Eating, peer-related Activities, Drugs, Sexuality, 	<ul style="list-style-type: none"> • Five focus groups with 42 participants – aged 18-21 years; 69% males • Quantitative analysis – descriptive statistics for survey data and medical record review • Qualitative analysis using descriptive and thematic content analysis specifically to identify knowledge gaps, barriers to disclosure and for seeking help • Triangulation was used to describe the data further 	<ul style="list-style-type: none"> • No statistical difference in characteristics of the sample between methods of screening (survey vs. medical record review) • Fifty percent completed the 12th grade • Twenty-five percent reported being pregnant or currently parenting • Psychiatric diagnosis recorded (53.5%); at least one suicide attempt(42%); greater than ten lifetime sexual partners reported (19.4%) • Involvement in justice system ($p < .01$) and foster care system ($p = .02$) and running away from home/being 	<ul style="list-style-type: none"> • Participants recruited from a single shelter in Houston, TX • Healthcare workers lack specialized training in identifying and addressing the needs of those undergoing HT. • Further research is needed to identify ways to help youth disclose their exploitation and remove barriers to disclosure. 	<p>Level: II Quality: B</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
		framework reported	Suicide/Depression (HEEADSSS) assessment • Focus group discussions conducted between August 2016 and March 2017, and each participant compensated with a \$10 gift card		kicked out ($p < .01$) • Forty-four percent reported being arrested vs. 13% in the medical record; thirty percent reported more than three arrests • Seventeen percent reported polysubstance abuse in the past • Medical records showed more documentation of labor exploitation than HTST survey • Identified need for survival and homelessness as the most significant factors to becoming a victim of HT • Fear and lack of trust identified as barriers to seeking help – including law enforcement discrimination and mistrust		

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					<ul style="list-style-type: none"> • The stigma associated with homelessness • Mistrust of mental health providers and hesitant to take prescription drugs • Inconsistency in sensitivity of screening measures is notable • HTST significantly more likely to ID sexual and labor exploitation than commonly used psychosocial assessment tool (HEEADSSS) • HTST more sensitive to identifying risk factors • Many states treat exploited youths like criminals. 		

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Mumma, B. E., Scofield, M. E., Mendoza, L. P., Toofan, Y., Youngyunpipatkul, J., & Hernandez, B. (2017). Screening for victims of sex trafficking in the emergency department: A pilot program. <i>Western Journal of Emergency Medicine</i>, 18(4), 616-620. doi: 10.5811/westjem.2017.2.31924</p>	<p>Evaluate the feasibility of using a screening survey and determine the most compelling questions for identifying adults who are being sex trafficked and compare to the sensitivity of emergency physician concern</p>	<ul style="list-style-type: none"> • Prospective observational cohort study • Convenience sample • Fourteen question survey tool • Institutional Review Board approved • Demographic and clinical information collected from EHR • No specific theory or conceptual framework reported 	<ul style="list-style-type: none"> • Single academic emergency department (ED) with 70,000 annual visits • N = 143 patients enrolled • Female patient – ages 18-40 years who were (1) medically stable in the Emergency Department (ED), (2) able to give consent, and (3) able to understand either English or Spanish; pregnant women were also included • Exclusions included patients < 18 years of age, prisoners, and those in the custody of 	<ul style="list-style-type: none"> • Fourteen question survey created • Takes 10-15 minutes to complete • Descriptive statistics using 95% confidence intervals • Sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) of the screening tool 	<ul style="list-style-type: none"> • Median age of 27 years • Overall, 46 screened positive (95% Confidence Interval (CI) [20, 35%]) • Ten identified as victims of HT (95% CI [13%, 41%]) – none were identified by the physician only • Sensitivity of screening survey (100%, 95% CI [74%, 100%]) compared to physician concern (40%, 95% CI [12, 74%]) • Physician specificity (91%, 95% CI [85%, 95%]) and slightly better than screening survey (78%, 95% CI [70%, 85%]). 	<ul style="list-style-type: none"> • It is feasible to identify adult victims of HT in the ED • Screening survey appears to have higher sensitivity as compared to physician concern • Single question screening may be enough to identify all adult victims of HT (sex trafficking) in the ED • Consistent with other studies, victims of HT receive much of their care in the ED • Victims of HT are not regularly recognized • A multi-disciplinary approach to caring for these patients is important 	<p>Level: II Quality: B</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
			<p>law enforcement</p> <ul style="list-style-type: none"> • Surveyed treating ED physicians; results were shared with them after they had documented their concern for sex trafficking • Any “yes” or concern documented was considered a positive screen • The survey tool pilot tested on 15 patients; these patients included in the overall study • The survey was verbally administered to patients in a private room with a visitor(s) present 		<ul style="list-style-type: none"> • All the identified victims of sex trafficking answered the following question positively: “Were you [or anyone you work with] ever beaten, hit, yelled at, raped, threatened, or made to feel physical pain for working slowly or for trying to leave?” 	<ul style="list-style-type: none"> • Future research needed to evaluate the use of this question as a stand-alone screening tool • Low sensitivity of physician concern demonstrates that it is a less effective method of screening victims • Limitations: The survey tool used has not been validated for use in the ED. The study sample was a convenience sample. • Unable to obtain longer-term follow up to determine the effectiveness of interventions 	

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Simich, L., Goyen, L., Powell, A., & Mallozzi, K. (2014). Final report: Improving human trafficking victim identification – validation and dissemination of a screening tool. <i>National Institute of Justice</i>, Award No.: 2011-MU-MU-0066. Retrieved from https://www.nejrs.gov/pdffiles1/nij/grants/246712.pdf</p>	<p>Design, field-test/validate a comprehensive screening tool for identification of victims of HT, victim services, and law enforcement efforts</p>	<ul style="list-style-type: none"> • Screening tool development and validation • Worked with 11 victim service providers (in CA, CO, NY, TX, and WA) • No specific theory or conceptual framework reported 	<ul style="list-style-type: none"> • Data collected on 230 cases – including interviews with victims and review of case files • Adults and minors included – domestic and foreign-born • Thirty-six in-depth service provider, survivors, and law enforcement interviews were conducted 	<ul style="list-style-type: none"> • Prediction of victimization in general • Predictors of labor trafficking in particular • Predictors of sex trafficking • Majority of questions focused on three domains: migration, work, and working/living conditions 	<ul style="list-style-type: none"> • N = 180 people responded to screening questions; 53% were trafficked victims. Forty percent were sex trafficked, and 60% were labor trafficked; forty-seven percent were victims of other non-trafficking crimes • Cronbach’s alpha for the entire tool: $\alpha = .91$, and for each scale within the tool: <ul style="list-style-type: none"> • Labor: $\alpha = .817$ • Violence/physical harm: $\alpha = .767$ • Sex: $\alpha = .753$ • Isolation: $\alpha = .610$ • Force, fraud, coercion: $\alpha = .825$ • Of the questions asked: <ul style="list-style-type: none"> • 87% significantly predicted 	<ul style="list-style-type: none"> • Validation methodology was described in detail and included results of construct validity with convergent and discriminant validity tested. Content and Criterion validity also tested. • Inter-rater and Internal consistency were tested, as was predictor reliability 	<p>Level: II Quality: A</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
					<p>victimization in general</p> <ul style="list-style-type: none"> • 71% significantly predicted labor trafficking, and • 81% significantly predicted sex trafficking • An abbreviated tool (16 questions) accurately predicted both labor and sex trafficking • Screening tool highly reliable in predicting victimization for both labor and sex trafficking across diverse sub-groups • Females more likely to experience sexual exploitation; males were more like to experience 		

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
					labor exploitation <ul style="list-style-type: none"> Trafficking victims more likely to report they spoke good/excellent English and to have more education as compared to non-trafficked victims 		
Varma, S., Gillespie, S., McCracken, C., & Greenbaum, V. J. (2015). Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. <i>Child Abuse and Neglect</i> , 44, 98-105. doi:10.1016/j.chiabu.2015.04.004	To develop an effective screening tool to identify characteristics of children at high risk for CSEC when they present for medical care and that differentiates them from non-CSEC sexual abuse or sexual assault	<ul style="list-style-type: none"> Prospective cohort study Development and validation of the screening tool A study conducted by a senior medical student IRB Approval Reviews conducted on patients suspected of CSEC who presented to any of the three EDs or one child protection clinic 	<ul style="list-style-type: none"> Major metropolitan children’s hospital in the southern US Ages between 12-18 years and who presented between January 1, 2011, and December 31, 2013 Control group formed CSEC patients were matched with controls based on the age of the first CSEC exam. 	<ul style="list-style-type: none"> Statistical significance at the .05 level Descriptive statistics including mean and SD t-test for continuous variables and Chi-square of independence in discrete cases For non-normality, Mann-Whitney U used N = 84 of which 27 were CSEC and 57 CSA victims 	<ul style="list-style-type: none"> Higher rate of prior STIs (53%) and physical abuse (44%), history of violence with sex (31%), and drug/alcohol use (70%) as compared to the age-matched control group No statistically significant difference in mental health disorders 46% of the CSEC cohort had seen a medical provider within the preceding two 	<ul style="list-style-type: none"> Lack of quantitative peer-reviewed research regarding risk factors for CSEC and health consequences Further study needed to differentiate factors that occurred before from those that occurred during exploitation to create prevention strategies 	Level: III Quality: B

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
		<ul style="list-style-type: none"> No specific theory or conceptual framework reported 	<p>At least two controls were sought for each case to reduce confounding effects and selection bias</p>	<ul style="list-style-type: none"> The average age of CSEC victim 15.7 years For CSEC victims: <ul style="list-style-type: none"> 56% African American Three males – all in the CSA group No significant demographic differences between the groups Statistically significant in the CSEC group: (a) sexually active prior to visit ($p = .001$), (b) frequency of condom use ($p = .010$), (c) history of STI ($p < .001$), (d) history of violence by parent ($p = .001$), and (e) history of drug/alcohol use ($p < .001$) 	<p>months, 75% within the past six months.</p>		

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
<p>Williams, P. R., Wyatt, W., & Gaddis, A. (2018). Identification of client involvement in sex trafficking in Mississippi. <i>Journal of Evidence-Informed Social Work, 15</i>(2), 170-185. doi:10.1080/23761407.2018.1430645</p>	<p>To quantify the occurrences of sex trafficking in Mississippi</p>	<ul style="list-style-type: none"> • Prospective (descriptive) cohort study • Nonprobability convenience sample • Sample initially estimated at 50 participants • Clients made aware that participation in the research study did not affect their ability to receive services • Principal Investigator performed all interviews and utilized a trauma-informed approach • Interview completed during the psychosocial history portion of the intake assessment • Informed consent 	<ul style="list-style-type: none"> • A social service agency in Jackson, MS • Men and women ages 18 years and older who interviewed for services with the agency • Exclusion criteria included non-English speaking clients and men and women not receiving services at the social services agency; participation was not open to the public • Ninety days in 2017 • Interviews were completed during daytime business hours and coincided with their scheduled 	<ul style="list-style-type: none"> • Independent variable: Trafficking in Victims Identification Tool (TVIT) (Vera Institute of Justice, 2014) • Cronbach’s alpha • Correlation • Quantitative measures • Dependent variables: participant age, housing status and location and whether the participant was controlled or coerced by a family member • Outcome variables: any trafficking, sex trafficking, or labor trafficking 	<ul style="list-style-type: none"> • N = 28 participants • Cronbach’s $\alpha = .91$ • The tool took 15 minutes to complete • Males: 46.6% • Average age: 39 years • Birth state: 67.9% were born in Mississippi • Education: More than 28% had more than a high school education, and 25% were high school graduates • All participants were English speaking • All participants had at least one classification from the narrative summaries suggesting sex trafficking • Researchers concluded 54% (n = 15) were 	<ul style="list-style-type: none"> • Sample size small and single location • Results are not generalizable • Provides benchmarking data for the state of Mississippi • Recommend including TVIT tool as part of client interview 	<p>Level: III Quality: C</p>

Title and Article Information	Purpose	Design, Method, and Conceptual Framework	Sample, Sample Size, and Setting	Tools, Major Variables, and Statistics Used	Analysis and Findings	Strengths and Limitations	Appraisal Level Strength and Quality
		completed for each participant • Data collected weekly and storage at a separate offsite location • No specific theory or conceptual framework reported	appointment at the agency		victims of sex trafficking		

Appendix D. Gap analysis

Ref No.	Item	Current State	Desired State	Focus Area	Action Items	Priority
1	Identification of HT victims	Current documentation requirements in the EHR do not capture sufficient information to identify HT victims consistently nor to provide analysis and follow up reporting on a regular basis.	Standardized list of "red flags" that can be tracked and analyzed to determine a correlation to HT victims and to validate the indicators that are published in the literature based on anecdotal reports.	Lack of consistency in documentation of indications of HT	* Work with Clinical Informatics team and EHR vendor resources to identify documentation and workflow gaps and opportunities * Create, build, test and implement a standardized screening tool to aid in the identification of victims.	High
2	Staff skills, abilities and behaviors	Some staff are reluctant to identify or report cases of violence/HT despite being a mandatory reporter. Some hospitals have identified very few if any victims over the course of the past three fiscal years. Example - there are three hospitals in Nevada and only 1 victim each of the three years has been identified.	All appropriate suspected or actual victims of violence and abuse, including HT are identified and reported	Lack of understanding of nurses' role in identification and care of HT victims	Create and provide education and training to nurses regarding use of the standardized screening tool and how to assess potential HT victims in a trauma-informed way	High
3	Communication and feedback loop	Current process for tracking HT victims who have been identified is VERY manually intensive with many dependent variables, barriers and time requirements to complete. Resources are not consistently made available to perform the data analysis and reporting in a timely manner.	Reports are provided consistently on a quarterly basis by the national office and more frequently ad hoc by the local teams.	Automate the process of collecting, reporting and trending statistics including number of victims identified, frequency of each specific indicator used to identify the victim, and connection of victims to support services and follow up care.	Create more timely feedback look regarding number of HT victims identified on a quarterly basis	High

Note. Human trafficking is abbreviated as HT.

Appendix F. Proposed Gantt chart: Standard HT screening tool for the EHR

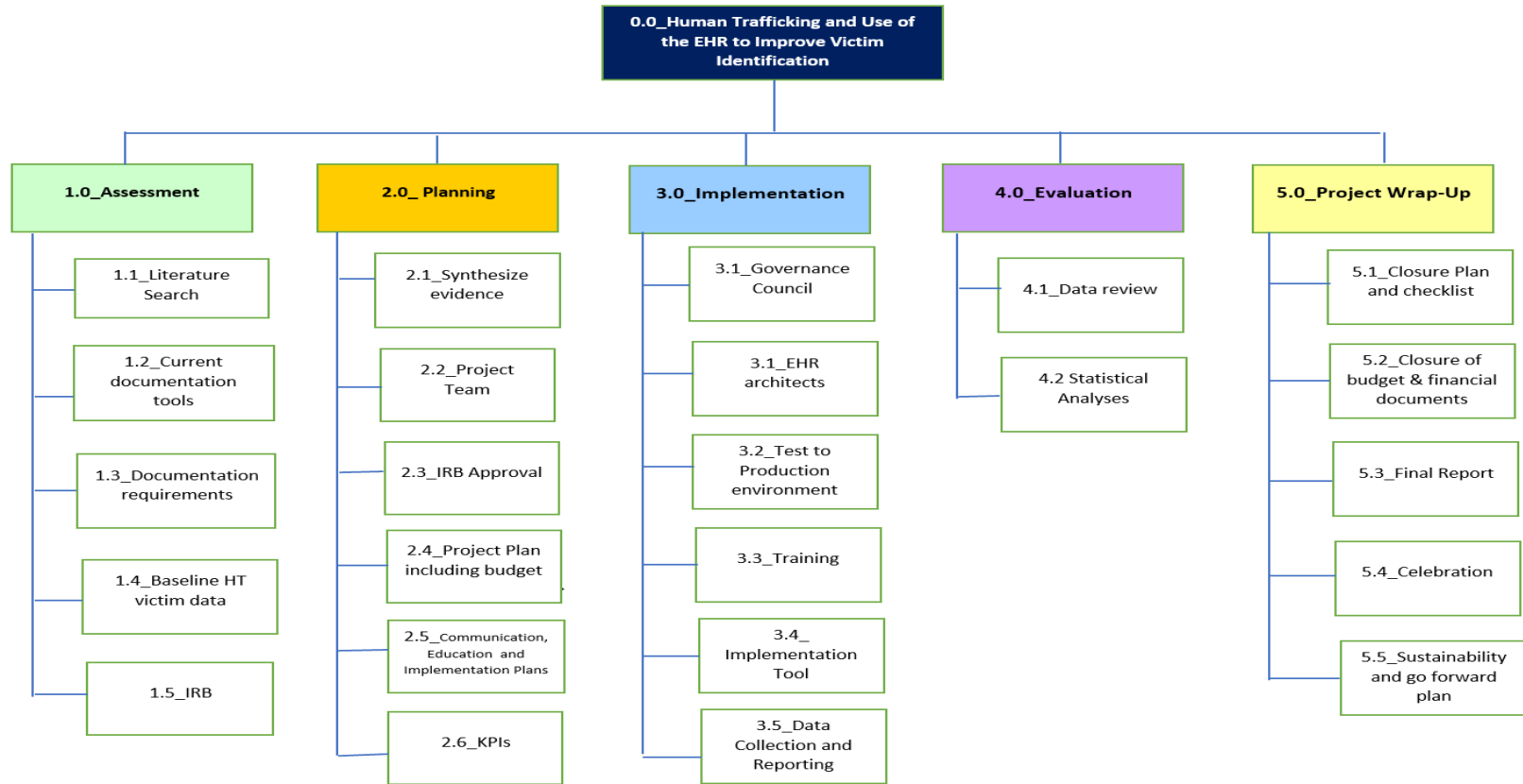
GANTT CHART: Standardized screening tool in EHR

★ = Milestone

Item	Task	Start	End	Completed	2020	2021							2022						
						May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr		
1	Assessment	Mar-19	Apr-19	100%	Previous work completed														
	Literature research, baseline data	Mar-19	Apr-19	100%															
2	Planning	Apr-19	Jun-19	100%															
	Synthesis the evidence	Apr-19	May-19	100%															
	Develop Project Plan and budget	Apr-19	May-19	100%															
	KPIs	Apr-19	May-19	100%															
	Vendor partner relationship	Apr-19	Jun-19	100%															
3	Project relaunch	May-21	Jun-21	0%															
	Review/revise project plan and budget	May-21	May-21	0%															
	Re-engage executive sponsor and key stakeholders	May-21	May-21	0%															
	Obtain approval to initiate project and confirm funding	May-21	May-21	0%			★												
	Engage informatics team and governance council	Jun-21	Jun-21	0%															
	Submit proposal to IRB	Jun-21	Jun-21	0%			★												
4	EHR changes	Jul-21	Nov-21	0%															
	Seek approval for EHR changes through governance process	Jul-21	Jul-21	0%															
	Confirm EHR changes and meet with clinical architects regularly on Design	Aug-21	Sep-21	0%															
	Test and validate in test environment	Sep-21	Oct-21	0%															
	Test and validate in production environment	Nov-21	Nov-21	0%															
5	Training of staff	Oct-21	Nov-21	0%															
	Create training materials	Oct-21	Oct-21	0%															
	Conduct training	Nov-21	Nov-21	0%															
6	Implement the screening tool - go live	Dec-21	Dec-21	0%															
7	Collect, monitor and analyze data; refresh training as needed	Dec-21	Mar-22	0%															
8	Project wrap-up	Apr-22	Apr-22	0%															
9	Celebrate and Sustain	Apr-22	Ongoing	0%															★

Note. This Gantt chart was built on the assumption that this project will resume in the second quarter of 2021.

Appendix G. Work breakdown structure



Appendix H. Strengths, Weaknesses, Opportunities and Threats analysis

Strengths	Weaknesses
<ul style="list-style-type: none"> • Combatting violence and abuse, including human trafficking (HT), is a priority established by the sponsoring congregations and women religious of Dignity Health (2014). • Human Trafficking Response Program is a formal program funded through philanthropy, grants, and fiscal support. • Dignity Health is a recognized leader in the fight against Human Trafficking and as a provider of HT training and education materials and services. • Staff have been trained on HT awareness • Existing relationships exist with national not-for-profit organizations focused on human trafficking. • Strong partnerships with the Cerner team. • Experienced team of clinical informaticists and clinical architects. • Data analytics team available if needed to support report writing and data abstractions for analysis. 	<ul style="list-style-type: none"> • Competing priorities and demands of clinical informatics and education resources. • Limited evidence related to know correlations between warning signs and victim identification. • Unknown true incidence of HT in the communities served.
Opportunities	Threats
<ul style="list-style-type: none"> • Contribute to the growing knowledge to improve the identification of victims of HT. • Contribute evidence and validation of the “red flags” of HT. • Expand learnings from the acute care areas of the Emergency Departments and Labor and Delivery Units to the ambulatory setting for improved recognition of victims and increase the rate of rescue and connection to community services. • Potential to collaborate further with law enforcement and community based social services on improved recognition and identification of victims. 	<ul style="list-style-type: none"> • Delay in building the functionality in the EHR. • Unrecognized staff bias that could negatively impact adoption. • Funding budgeted for the project may be exceeded if significant challenges are encountered with the EHR functionality build. • Delayed or inconsistent adoption of new practices. • Lack of buy-in or turnover in department leadership could negatively impact implementation units/facilities.

Appendix I. Budget

Project Budget



HUMAN TRAFFICKING						Total	BUDGET	ACTUAL	UNDER (OVER)
Project Dates: Jan. 2019 - June 2020							\$ 1,730,655.00	\$ 192,830.00	\$ 1,537,825.00
WBS	Task	CI LABOR		EDUCATION MATERIALS		Fixed Costs	Budget	Actual	Under (Over)
		Hrs	Rate	Hours	\$/Hour				
EHR COMPONENT									
1.0	Changes						\$ 9,610.00	\$ 4,810.00	\$ 4,800.00
1.1	Identify EHR fields - Current	6.0	\$ 75.00			\$ -	\$ 450.00	\$ 400.00	\$ 50.00
1.2	Identify # Survivors by Service Area	80.0	\$ 52.00			\$ -	\$ 4,160.00	\$ 4,410.00	\$ (250.00)
1.3	IRB	0.0	\$ -			\$ 5,000.00	\$ 5,000.00	\$ -	\$ 5,000.00
2.0	EHR Project						\$ 32,175.00	\$ 10,750.00	\$ 21,425.00
2.1	Identify EHR Changes	25.0	\$ 75.00			\$ -	\$ 1,875.00	\$ 1,250.00	\$ 625.00
2.2	Design Team	100.0	\$ 75.00			\$ -	\$ 7,500.00	\$ 4,500.00	\$ 3,000.00
2.3	Establish Vendor Team	50.0	\$ 200.00			\$ -	\$ 10,000.00	\$ 5,000.00	\$ 5,000.00
2.4	Build New Design in Test Environment	100.0	\$ 100.00			\$ -	\$ 10,000.00	\$ -	\$ 10,000.00
2.4.1	Test Build	24.0	\$ 100.00			\$ -	\$ 2,400.00	\$ -	\$ 2,400.00
2.5	Demo Build in Test Environment	4.0	\$ 100.00			\$ -	\$ 400.00	\$ -	\$ 400.00
EDUCATION COMPONENT									
3.0	Education						\$ 178,270.00	\$ 177,270.00	\$ 1,000.00
3.1	Meet with Dir. HTR			2.0	\$ 65.00	\$ -	\$ 130.00	\$ 130.00	\$ -
3.2	Define Learning Objectives			8.0	\$ 45.00	\$ -	\$ 360.00	\$ 360.00	\$ -
3.3	Meet with SMEs			6.0	\$ 45.00	\$ -	\$ 270.00	\$ 170.00	\$ 100.00
3.4	Develop Draft			245.0	\$ 45.00	\$ -	\$ 11,025.00	\$ 9,000.00	\$ 2,025.00
3.4.1	Build in Captivate			1,000.0	\$ 75.00	\$ -	\$ 75,000.00	\$ 75,000.00	\$ -
3.4.2	Vet with SMEs			16.0	\$ 45.00	\$ -	\$ 720.00	\$ 720.00	\$ -
3.5	Upload into LMS & Assign to Staff by Role			9.0	\$ 45.00	\$ -	\$ 405.00	\$ 270.00	\$ 135.00
3.6	Write Report to Track Completion of Training			12.0	\$ 30.00	\$ -	\$ 360.00	\$ 270.00	\$ 90.00
3.8	Staff complete training (pre/post) - pilot sites (2 hrs. @ \$75/hr x 300 employees) x 2			600.0	\$ 150.00	\$ -	\$ 90,000.00	\$ 91,350.00	\$ (1,350.00)
IMPLEMENTATION*									
4.0	Implement	\$ 100.00					\$ 1,470,600.00	\$ -	\$ 1,470,600.00
4.1	Activate new Screening Tool in EHR Production Environment	4.0	\$ 100.00	0.0	\$ -	\$ -	\$ 400.00	\$ -	\$ 400.00
4.2	Train Staff	100.0	\$ 35.00			\$ -	\$ 3,500.00	\$ -	\$ 3,500.00
4.2.1	HT Modules (2 hrs./employee @ \$75/hr x 6500 clinicians)	0.0	\$ -	13,000.0	\$ 75.00	\$ -	\$ 975,000.00	\$ -	\$ 975,000.00
4.2.2	EHR Documentation (1 hr/clinician)	0.0	\$ -	6,500.0	\$ 75.00	\$ -	\$ 487,500.00	\$ -	\$ 487,500.00
4.3	Monitor Compliance	26.0	\$ 50.00	0.0	\$ -	\$ -	\$ 1,300.00	\$ -	\$ 1,300.00
4.3.1	Analyze Data	52.0	\$ 50.00	0.0	\$ -	\$ -	\$ 2,600.00	\$ -	\$ 2,600.00
4.3.2	Generate Reports and Distribute	6.0	\$ 50.00	0.0	\$ -	\$ -	\$ 300.00	\$ -	\$ 300.00
5.0	Close Out Project						\$ 40,000.00	\$ -	\$ 40,000.00
5.3	Plan and Execute Celebration	4.0	\$ -			\$ 40,000.00	\$ 40,000.00	\$ -	\$ 40,000.00

* Note. Screening tool template in EHR portion of project placed on hold in February, 2020 due to global pandemic.

Note. IRB = Institutional Review Board; HTR = Human Trafficking Response Program; LMS = Learning Management System; SMEs = Subject Matter Experts; EHR = Electronic Health Record

Appendix J. Statement of non-research determination – USF**DNP Statement of Non-Research Determination Form****Student Name:** CONNIE CLEMMONS-BROWN**Title of Project:**

Use of the electronic health record (EHR) to improve the identification of patients at high risk for human trafficking.

Brief Description of Project:**Aim Statement:**

The aim of this study is to add to the knowledge base of the “red flags” or indicators for the identification of patients at high risk for human trafficking.

Description of Intervention:

A standardized, templated assessment and documentation tool will be built in the electronic health record and incorporated into the nursing assessment process. The data collected from this tool will then be used to identify the criteria used to identify patients who are trafficked and compare these “red flags” to those themes identified in current practice. A retrospective review of data will determine whether the standardized information gathered in the assessment form will improve the identification of patients who are at risk for sexual and/or labor trafficking.

How will this intervention change practice?

Currently there are several published “red flags” that are touted as indication of persons at high risk for sexual or labor trafficking. The literature is sparse as to the evidence to support the specificity and sensitivity of these indicators.

Outcome measurements:

1. Completion rates of the assessment tool.
2. Number of patients identified who are at high risk or who (admittedly) are being trafficked as documented in the EHR.
3. Frequency of occurrence of each of the indicators of human trafficking.
4. Correlation between indicator of human trafficking and patient identified as being trafficked.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:

(<http://answers.hhs.gov/ohrp/categories/1569>)



This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments: None

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	YES	NO
Use of the electronic health record (EHR) to improve the identification of patients at high risk for human trafficking.		
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	YES	
The specific aim is to improve performance on a specific service or program and is a part of usual care . ALL participants will receive standard of care.	YES	
The project is NOT designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does NOT follow a protocol that overrides clinical decision-making.	YES	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.	YES	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	YES	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	YES	
The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	YES	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	YES	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <i>"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."</i>	YES	



ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print):

Connie Clemmons-Brown

Signature of Student:

Connie A. Clemmons-Brown DATE: 09/01/2019

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):

Dr. KT Waxman

Signature of Supervising Faculty Member (Chair):

KT Waxman DATE: _____

Appendix K. Statement of non-research determination – Dignity Health

~ PLACE HOLDER ~

SUBMISSION TO IRB DELAYED DUE TO COVID-19

OBTAIN WHEN ABLE TO RESUME PROJECT

Note. The statement of non-research determination was withdrawn from consideration and will be resubmitted once the project can resume.

Appendix L. Letter of support from the clinical site

Note. This support letter includes implementing the DNP project in acute care facilities at Dignity Health, as part of CommonSpirit Health, and then throughout the remaining facilities in future phases.

Appendix M. Project roles and responsibilities

Role	Responsibilities	Assigned to
Executive Sponsor	<ul style="list-style-type: none"> • Authorizes and has ultimate authority/responsibility for the project. • Determines and approves the scope of the project, deliverables, and timeframes. 	<ul style="list-style-type: none"> • System Chief Nursing Officer
Executive Committee	<ul style="list-style-type: none"> • Allocates resources. • Recommends and authorizes communication plan. 	<ul style="list-style-type: none"> • Patient Care Services Executive Leaders
Project Sponsor	<ul style="list-style-type: none"> • Approves all project-related work products. • Makes project-related business decisions. 	<ul style="list-style-type: none"> • Connie Clemmons-Brown
Project Manager(s)	<ul style="list-style-type: none"> • Develops project plans and deliverables. • Manages project plan and monitors status. • Provides project status reports and escalates risk issues. • Manages project resources. • Maintains documentation. • Coordinates meetings and trainings. 	<ul style="list-style-type: none"> • Enterprise Clinical Informaticist
Project Team Members – EHR	<ul style="list-style-type: none"> • Works with Project Sponsor and Project Manager to achieve project objectives and deliverables related to EHR build and report writing. 	<ul style="list-style-type: none"> • Clinical Informatics Build Team • Cerner Build Team
Project Team Members – Education	<ul style="list-style-type: none"> • Works with Project Sponsor and Project Manager to develop training related to: <ul style="list-style-type: none"> ○ Documentation requirements in EHR ○ Changes in the workflow for nurses ○ “Red Flags” criteria and importance of complete documentation ○ Conducting screening/assessment and providing care in a trauma-informed manner. 	<ul style="list-style-type: none"> • System Director, Clinical Education
Stakeholders	<ul style="list-style-type: none"> • Participate in the project as needed; provide input and feedback 	<ul style="list-style-type: none"> • Executive Team • Department Leaders – ED and Labor and Delivery • Staff – ED and L&D • Director, Human Trafficking Response Program • Mission leaders • Informatics Leaders and teams • Clinical Educators
Analyst	<ul style="list-style-type: none"> • Provide data analysis regularly to Project Sponsor, Project Manager, Executive team, department leaders, and key stakeholders and staff. 	<ul style="list-style-type: none"> • To be assigned

Appendix N. Communications plan

Communication	Method	Frequency	Goal	Owner	Audience
Project Status	Email	Weekly	Review project status; identify and discuss potential issues, delays, risks and barriers	Project Manager	Project Sponsor; Project Team
Team Meetings	Webex	Weekly	To review team progress and adherence to timeframes	Project Manager	Project Team
Project Review	Webex	At Milestone achievement	To identify and confirm project deliverables; review progress and next steps	Project Manager	Project Sponsor; Project Team
Training compliance	Email	2 x - at 14 days and 30 days after training assigned in Learning Management System	To keep department leaders apprised of staff completion rates	Project Manager	Department Leaders of ED and Labor & Delivery
Documentation completion rates	Email and webex	Weekly for 1st month, then biweekly until end of project	To keep department leaders apprised of staff compliance and to identify high performers and areas for opportunity	Project Manager	Department Leaders of ED and Labor & Delivery
# of Trafficking Victims identified	Email	Monthly	To reinforce importance of the screening and to recognize performance	Project Manager	Department Leaders and staff of ED and Labor & Delivery
Post-mortem	Meeting	At the end of project	Debrief to identify key take-aways, areas for improvement, actionable items for follow-up	Project Manager	Project Team

Note. Adapted from Martinelli, R. J., & Milosevic, D. Z. (2016). *Project management toolbox* (2nd ed.). Hoboken, NJ: John Wiley & Sons.

Appendix O. Benefit-cost analysis

As one of the nation's largest not-for-profit, faith-based health care systems, Dignity Health is a known leader in the fight against human trafficking. The DNP evidence-based practice change project seeks to create and implement a standardized screening tool and training program to help clinicians identify the most vulnerable in their communities.

A benefit-cost analysis is needed to determine whether or not the project is beneficial and feasible.

The following assumptions were used in calculating the benefit-cost ratio:

1. Average hourly wage of clinicians = \$75.00
2. The three training modules require two hours to complete.
3. Globally, human trafficking results in \$150 billion in illegal profits to perpetrators and it is estimated that there are 24.9 million adult and child victims (ILO, 2017). The average profits generated by each trafficking victim, according to Human Rights First (2017) is \$21,800, and up to \$100,000 for each victim who is sexually exploited.
4. Nineteen percent of victims are sex trafficked, yet they account for 66% of human trafficking profits globally (Human Rights First, 2017).
5. According to the National Human Trafficking Hotline (2019), there were 1,980 human trafficking cases reported in California (n=1,507), Nevada (n=239), and Arizona (n=234).
6. The total cost to create the interactive learning modules = \$88,270
7. The number of clinicians who were assigned 330; the number of clinicians who successfully completed the modules with a passing score of 80% or greater on the ten comprehension questions is 91.5% (n=302).

Investment

Total cost of producing three interactive modules		\$ 88,270.00
Total number of clinicians in pilot sites	330	
Cost / clinician		\$ 267.48
Total number of applicable clinicians across CommonSpirit Health	6,500	
Cost / clinician		\$ 13.58

The benefits come in societal benefits that are difficult to definitively quantify. Assuming that each human trafficking victim generates \$21,800, each victim that is identified and rescued would reduce these profits.

A ten percent increase in the number of victims identified as compared to 2018 would result in 10 additional victims. Ninety-six victims x 10% increase would result in an average of \$21,800 x 10 = \$218,000 in savings to society or loss of profit to perpetrators, just in the communities served by CommonSpirit Health.

Using the benefit-cost ratio (BCR):

$$\frac{\text{Present value of Benefit expected from project} = \$ 218,000}{\text{Present value of Cost expected from project} = \$ 88,270} = 2.47$$

Given that the BCR is > 1 or positive, implementation of the DNP project is feasible and beneficial to the organization.

Appendix P. Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> • Patients \geq 15 years of age who present to a Dignity Health facility emergency department (ED) or labor and delivery unit (L&D) seeking care 	<ul style="list-style-type: none"> • Patients \leq 14 years of age • Patients who present to any department other than the emergency department or labor and delivery unit seeking care • Patients who arrive in the ED or L&D in cardiopulmonary arrest • Patients who do not have a screening for violence/human trafficking completed

Note. This project focused on adult patients. Medical staff bylaws define pediatric patients. The average age of a child engaged in commercial sex trafficking is 15 years of age National Center for Missing and Exploited Children. (2019). Child sex trafficking. Retrieved from <http://www.missingkids.com/theissues/trafficking>.

Appendix Q. American Hospital Association: 10 red flags

Human Trafficking

10 Red Flags that Your Patient Could be a Victim

- 1 Clinical presentation and oral history don't match up
- 2 Oral history is scripted, memorized or mechanical
- 3 Someone with the patient exerts an unusual amount of control over the visit
- 4 Patient appears fearful, anxious, depressed, submissive, hyper-vigilant or paranoid
- 5 Patient is concerned about being arrested or jailed
- 6 Patient is concerned for his/her family's safety
- 7 Evidence that care has been lacking for prior or existing conditions
- 8 Tattoos or insignia's indicative of ownership
- 9 Occupational-type injuries or physical ailments linked to their work
- 10 Sexually transmitted infections

HOSPITALS AGAINST VIOLENCE

American Hospital Association
Advancing Health in America

Resource adapted from materials developed by Catholic Health Initiatives.

Note. American Hospital Association. (2018). Human trafficking: 10 red flags that your patient could be a victim. Retrieved from <https://www.aha.org/system/files/2018-07/human-trafficking-infographic.pdf>.

Appendix R. Learning modules



Learning Objectives



Human trafficking, or **trafficking in persons**, is a particular type of violence that is pervasive yet widely misunderstood. To prevent this crime and respond to affected patients, we must first understand it. In the following slides, we will cover basic information about human trafficking. The learning objectives are to

- **Define** human trafficking
- **Recognize** myths/ misconceptions associated with this type of violence
- **Identify** vulnerable populations and high-risk industries, and
- **Take action** to prevent trafficking and respond to victims appropriately


Every country is affected by human trafficking, **including the United States.**² CommonSpirit has initiatives in place to address human trafficking in many countries, including India and Nepal. However, this presentation is focused on efforts to prevent and respond in the U.S.

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Learning Objectives



In this module, we will introduce the topic of trauma and the importance of a trauma-informed approach in health care settings. The learning objectives are to:

- **Describe** the prevalence and widespread impact of trauma
- **Recognize** signs and symptoms of trauma (i.e., traumatic stress), including secondary traumatic stress, and
- **Consider** the impact of trauma and respond in meaningful ways


NOTE: This is an introductory module on trauma-informed care; it is not designed to educate learners on how to screen people for trauma. Following this module, learners should recognize that most individuals have experienced trauma and should consider the impact of traumatic stress on themselves and others. For additional information about trauma-informed approaches in your discipline, please consult with your supervisor.

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Learning Objectives



The learning objectives for this module are to:

- **Educate** patients about abuse, neglect, and violence,
- **Assist** patients with referrals to community agencies, and
- **Access** resources and tools that can assist with this process

Recommended prerequisites include education on various forms of abuse, neglect, and violence, including human trafficking, and education on a trauma-informed approach to patient care.

Education on human trafficking, trauma-informed patient care, and other topics is available from CommonSpirit Health and CommonSpirit's Violence and Human Trafficking Prevention and Response Program.

Learn more:
commonspirit.org/united-against-violence

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Note. Updated interactive learning modules (CommonSpirit Health [CSH], 2020a; CSH, 2020b; CSH, 2020c)

Appendix S. Data table example

DATA ELEMENT	Number	Percent	<i>Facility</i>
<i>Gender</i>			<i>Department</i>
Male			Emergency Department
Female			Labor & Delivery
Other			# RN Staff
<i>Age</i>			Emergency Department
< 12 years			Labor & Delivery
12 - 18 years			# RN Staff Trained
19 - 25 years			Emergency Department
26 - 35 years			Labor & Delivery
36 - 45 years			% RN Staff Trained
46 - 55 years			Emergency Department
> 55 years			Labor & Delivery
<i>State</i>			
Arizona			
California			
Nevada			
<i>Identified as Suspected victim?</i>			
Yes			
No			
<i>Identified as a Confirmed victim?</i>			
Yes			
No			
<i>If yes, type of exploitation</i>			
Forced labor			
Commercial sex			
Both			
<i>Support services offered?</i>			
Yes			
No			
<i>Of Support services offered, % accepted.</i>			
<i>Red Flags identified</i>			
None			
0 - 1			
2 - 4			
5 - 7			
8 - 10			

Note: This table is an example of the type of data that can be reported. The actual format may vary in future versions.

Appendix T. Results

Table 1.

Baseline: Victims identified 2016-2019

Fiscal Year	Human Trafficking Victimization Indicator Level		
	Low	Moderate	High
2016	7	11	20
2017	3	48	28
2018	1	62	96

Note: Baseline data for human trafficking victims at Dignity Health. These numbers represent victims identified based on manual retrieval and review of case summaries.

Table 2.

Education Completion Results

	# Clinician assigned learning module	Successfully completed (%)
Baseline (March 1 – 31, 2020)	307	87.1%
Follow-up (September 1 – 30, 2020)	302	91.5%

Note. Learning modules assigned to the ED staff only in three Dignity Health Hospitals in southern California. Successful completion requires a score of 80% on the 10-question comprehension examination.

Appendix U. Human trafficking victim outreach posters

You can be in control of your life.



I realized I needed help. So I asked for support—and now I feel unharmed and in control.

- Were you tricked into running away or leaving your home?
- Did someone trap you in a job?
- Is your job different from what you were promised?
- Are you getting paid for all the work you do?
- Are you forced or pressured to trade sex for money, or to have sex with people you don't want to?
- Are you afraid to leave?
- Is your ID or other documentation being held by someone else?

These are all signs of human trafficking or other types of abuse. Talk to your physician or nurse, or ask to speak with a social worker now. You can learn more about your options—including long-term needs like housing, education, legal advice, and finding a job.

Pedí ayuda. Ahora tengo control sobre mi vida.



Usted merece sentirse a salvo, no importa lo que le hayan dicho.

- ¿Lo engañaron para que huyera o dejara su hogar?
- ¿Alguien lo mantiene trabajando en contra de su voluntad?
- ¿Su trabajo no es el que le prometieron?
- ¿Le pagan por todo el trabajo que hace?
- ¿Lo obligan o presionan para intercambiar sexo por dinero o para tener relaciones sexuales con personas que no quiere?
- ¿Tiene miedo de huir?
- ¿Otra persona retiene su documento de identidad u otro documento?

Todos estos son signos de trata de personas u otros tipos de abuso. Hable con su médico o enfermera, o pida hablar con un trabajador social ahora. Puede obtener más información sobre sus opciones, incluidas las necesidades a largo plazo, como vivienda, educación, asesoramiento legal y cómo encontrar trabajo.

National Human Trafficking Hotline
 ☎ 1-888-373-7888
 HumanTraffickingHotline.org



Linea Directa Nacional de Trata de Personas
 ☎ 1-888-373-7888
 HumanTraffickingHotline.org

Note. In response to California Senate Bill 225 (SB 225) (State of California, 2017), human trafficking victim outreach posters were created, co-branded with the National Survivor Network (NSN), and distributed to Dignity Health facilities to display in emergency departments, urgent care centers, and labor and delivery departments. Human trafficking victim outreach posters are produced in two sizes, 85.x11 inches and 11x17 inches, and translated into nine different languages.

Appendix V. Current federally funded human trafficking grants

Grantor	Award #	Link to Grant Award	Grant Amount	Summary
U.S. Department of Justice Office for Victims of Crimes	2018-V3- GX-K065	https://ovc.ojp.gov/funding/awards/2018-v3-gx-k065	\$ 948,921 No match funding required 24-month period of performance	Advancing hospital-based victim services demonstration initiative: Funding is provided to enhance the efforts of the Medical Safe Haven Clinic for victims of human trafficking (HT) in three Dignity Health hospitals in Bakersfield, CA. Specifically, the grant will support the following efforts: (1) development of a hospital-based HT response model, (2) validate the PEARR Tool, (3) implement procedures and trauma-informed staff training, and (4) build a community response to aid survivors in their physical and emotional recovery.
	2018-VT- BX-0025	https://ovc.ojp.gov/funding/awards/2018-vt-bx-0025	\$ 648,184 25% match funding 36-month period of performance	Specialized services for victims of human trafficking program: Funding is provided to improve HT victims' services as defined by the Trafficking Victims Protection Act of 2000 (TVPA, 2000). Specialty services in five priority areas have been identified under this grant (housing services, legal services, substance use services, education services, and mental health services). Dignity Health will leverage services (local, state, and federal) to expand community capacity to provide mental health services to all HT victims through public awareness activities, professional training, and interagency partnership development in three California communities served by Dignity Health: Sacramento, Redding, and Northridge.
	2019-VT- BX-K011	https://ovc.ojp.gov/funding/awards/2019-vt-bx-k011	\$ 899,311 25% match funding 36-month period of performance	Innovations in assistance to victims of human trafficking solicitation: In partnership with the Coalition to Abolish Slavery and Trafficking (CAST) and Journey Out, Dignity Health will implement an innovative onsite survivor advocate as part of the victim response team. This aim is to expand upon the survivor advocate model piloted in 2018 and extend it to clinics, sharing findings nationwide.

Note. These grants were awarded to Dignity Health in 2018, but their implementation was delayed until late 2019 and early 2020 due to delays in obtaining IRB approval.