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Promoting Recognition and Rescue: Human Trafficking Screening

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Contents

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Executive Summary

The exploitation of human beings is a serious public health concern (Centers for Disease Control [CDC] 2018). The U.S. Department of State identified over 100,000 victims of human trafficking globally in 2017. Thousands of these victims reside in the United States and seek healthcare during captivity (U.S. Department of State, 2018). Texas is among the highest human trafficking states and Parkland hospital hosts the busiest emergency department (ED) in the country (National Human Trafficking Hotline, 2019). This data supports the conclusion that trafficking victims seek medical treatment at Parkland, yet to date there is no education or established process specifically addressing this vulnerable population. Furthermore, House Bill 2059, enacted during the 86th Texas Legislative session requires completion of a human trafficking prevention course for all direct care nurses upon license renewal effective September 1st, 2020 (Texas Board of Nursing [TBON], 2020). Given the clinical importance and new state requirements, a benchmark project promoting human trafficking knowledge and victim recognition within the emergency department should be prioritized. The proposed project aims to improve identification of human trafficking victims seeking treatment at Parkland emergency department through implementation of an employee education program and utilization of a screening tool. This twelve-week benchmark project is grounded in evidence-based practice, cost efficient, involves a multidisciplinary approach, and has minimal workflow impact. As leaders and decision makers within this organization, you have been called to make ethical decisions which promote patient safety. Parkland's current screening process fails to recognize victims of human trafficking, thereby preventing opportunities for rescue. In order to save this vulnerable patient population we must first recognize them. Please consider approving the human trafficking benchmark project and help give trafficking victims a fighting chance.

Promoting Recognition and Rescue: Human Trafficking Screening

The United States Department of Justice (2018) defines human trafficking as an act of coercing a person's labor services or commercial sex acts. The extent of this public health crisis is likely underestimated due to knowledge gaps and inconsistent screening protocols. Recent media attention and research pioneers have made headway in human trafficking awareness, but our healthcare systems are behind. Parkland currently does not screen for victims of human trafficking and there is no education program for employees to assist in victim awareness. Every day vulnerable victims of human trafficking seek treatment at hospitals across the country and everyday healthcare workers are missing critical opportunities for recognition and rescue (Emergency Nurses Association, 2018). This benchmark project seeks to improve human trafficking identification by implementing evidence-based practice measures. This paper will provide evidence supporting the proposed interventions and outline the implementation plan.

1. Rationale for the Project

Of the 561 trafficking cases reported to the Human Trafficking Hotline in Texas only 140 victims reported being referred (National Human Trafficking Hotline, 2019). This translates to missed opportunities for rescue; likely by healthcare workers. Despite the alarming prevalence of trafficking, healthcare systems across Texas lack processes to promote recognition of trafficking victims (Dols, Beckmann-Mendez, McDow, Walker, & Moon, 2019). A survey of 99 South Texas emergency departments revealed 59% of respondents did not screen for human trafficking and those that did were not effective in identifying victims (Dols et al., 2019). Absence of standardized trafficking screening tools and the lack of defined protocols for administration explain hospital discrepancies in victim identification.

The Joint Commission (2018) encourages healthcare facilities to screen for trafficking victims and emphasizes the need to provide privacy and utilize a medical interpreter during the assessment. Currently, Parkland emergency department exclusively screens for domestic violence during the psychosocial nursing assessment and does not provide direction for administering the assessment. In the last two years, no human trafficking victims have been identified at Parkland emergency department using the domestic violence screening tool. This information highlights flaws in the current screening process and translates to missed rescue opportunities for victims of human trafficking. This benchmark project seeks to promote victim disclosure by implementing the following measures: requiring use of a medical interpreter (if necessary), ensuring privacy, and modifying the screening to include questions directly related to human trafficking. Additionally, there is no education on human trafficking provided to Parkland employees. In an effort to improve employee awareness and victim recognition, this project will also include implementation of a human trafficking education module.

By not providing a safe opportunity to disclose abuse, Parkland is sending patients back into dangerous and potentially deadly circumstances. Lack of human trafficking education and standardized screening processes deprive healthcare providers of the tools and knowledge needed to identify victims. This benchmark project aims to improve the number of human trafficking victims identified at Parkland by eliminating barriers to victim recognition. Evidence supporting these interventions will be discussed in the literature review.

2. Literature Synthesis

A thorough literature search was conducted using the following databases: CINHAL, Pubmed, and Cochrane. Search criteria included peer-reviewed articles published from January of 2015 to January of 2020 and included the keywords human trafficking, screening tools, and

emergency departments. Articles were excluded if the study was completed outside the United States. The literature search focused on screening tools and their implementation within emergency departments specifically related to the clinical question. The initial search yielded 25 peer reviewed articles. Twelve articles were selected based on applicability in setting, similarities in population, or ability to benchmark. Articles were critically appraised, and results summarized into an evidence table (see Appendix A). The literature review provided evidence of discernable correlations between employee education, the use of a screening tool, and accurately identifying victims of human trafficking (Egyud et al., 2017; Kalisto et al., 2017; Mumma et al., 2017).

Tool Variability

There is sufficient evidence supporting development, assessment, and validation of human trafficking screening tools. Bespalova, Morgan and Coverdale (2016) completed a literature review on human trafficking screening tools and found only 2 of the 9 screenings were appropriate for healthcare settings and none of these tools were validated. Inconsistencies in screening processes are partially caused by the lack of validated healthcare screening tools (Bespalova et al., 2016). Dols et al. (2019) assessed the status of human trafficking screening in South Texas emergency departments and provided further evidence of variability in human trafficking screening. Most survey respondents screened for trafficking by assessing intimate partner violence with inconsistencies in administration, timing and location (Dols et al. 2019). Screening processes resulted in no identified adult human trafficking victims over a year in 27 South Texas Emergency Departments (Dols et al. 2019). The discrepancies in identified victims throughout emergency departments and significant variability of screening measures

demonstrates the impact of ineffective screening and supports further research promoting standardization of a screening tool for healthcare providers.

Tool Effectiveness

Evidence demonstrates the effectiveness of a screening tool in identifying victims of human trafficking. Studies which focused on evaluating screening tools produced statistically significant results exhibiting accuracy in victim recognition. Overall tools demonstrated >85% sensitivity and high negative predictive values (NPV). A prospective cohort study successfully validated the Quick Youth Indicators for Trafficking (QYIT) tool to screen homeless for trafficking (Chisolm-Straker et al., 2019). The QYIT tool, based on the VERA institute screening criteria, identified 30 (8.8%) trafficking victims of the 307 participants. The QYIT screening tool was brief, and at least one positive answer was 86.7% sensitive for trafficking (Chisolm-Straker et al., 2019). Kalisto et al., (2017) analyzed a 6-question pediatric trafficking screening tool and determined 11 (5.4%) of the 203 participants were sex trafficking victims. The tool was found to demonstrate a sensitivity of 90.9% and a NPV of 99% amongst trafficked victims. Greenbaum Dodd, and McCracken (2018) completed a multisite cross-sectional observational study evaluating prevalence of trafficking amongst pediatric patients and determined 2 positive answers on a 6-item screening was highly sensitive. Greenbaum et al. (2018) discovered a trafficking prevalence of 11.1% amongst the 810 children screened and an NPV of 96.7% (CI 95% 94.6-98.2) (Greenbaum et al., 2018). These tools despite being population specific, establish evidence supporting implementation by demonstrating improved victim recognition. Furthermore, hospitals which implemented screening protocols saw increases in victims identified (Egyud et al., 2017; Mumma et al., 2017). A pilot study conducted with 142 female patients identified a 100% true yes response rate to “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?" (Mumma et al., 2017). Egyud et al. (2017) implemented an evidence-based practice project which evaluated a screening tool, treatment algorithm, and employee education in identification of human trafficking victims. This project successfully identified 38 potential victims over a 5-month period and rescued five patients from abusive conditions (Egyud et al., 2017).

Implementation of Red Flags

Recognition of characteristic behaviors, common complaints, and red flags are important elements of victim recognition and employee education (Egyud et al., 2017; Donahue et al., 2019). Baldwin, Eisenman, Sayles, Ryan, and Chuang (2011) analyzed healthcare encounters experienced by trafficking victims to promote victim recognition. Sex trafficking victims commonly sought treatment for sexually transmitted infections or abortions, whereas human trafficking victims required treatment for neglected injury or respiratory illness which prevented the ability to work (Baldwin et al., 2011). Behaviors identified amongst trafficked youth ages 11-17 include history of sexually transmitted disease (83.3%), drug or alcohol use (66%), and history of running away (74%) (Greenbaum et al., 2018). Gerassi, Nichols, Cox, Goldberg and Tang (2018) determined mental health symptoms (depression, low self-esteem, anxiety) to be the most common indicators of trafficking. Gerassi et al. (2018) discovered respondents observed lower incidences of overt signs indicating trafficking such as tattoos, branding, or signs of torture. This research supports the use of red flags as potential indicators for human trafficking but also expresses the importance of comprehensive patient assessments. Although awareness of red flags can assist in victim recognition, provider instinct alone is not as effective as the use of a screening tool (Mumma et al., 2017).

Educational Interventions

Educational interventions and knowledge of human trafficking indicators improve victim identification. Berishaj, Buch, and Glembocki (2019) concluded attendance of an educational conference on human trafficking improved both awareness and beliefs regarding human trafficking amongst nurses in attendance. Egyud et al. (2017) concluded education improves administration compliance and employee competence in human trafficking (Egyud et al., 2017). Implementation of an online training module was 92% useful among survey participants and improved employee confidence in victim recognition from 49% pre education to 94% post education (Donahue et al., 2019).

3. Project Stakeholders

Hospital leadership, nursing staff, medical providers, and social workers are all stakeholders in this benchmark project. Stakeholders seek improved patient safety outcomes, minimal workflow disruptions, appropriate resource allocation, multidisciplinary approach and cost efficiency which have all been considered throughout development of this benchmark project (Hockenberry, Brown, & Rodgers, 2015, p. 206). In addition to the beforementioned stakeholders, patients and victims of human trafficking will also be impacted. Patient preferences can be considered through understanding of priorities, beliefs, and values. This is a difficult concept for victims of human trafficking who often endure significant psychological abuse (Hachey & Phillippi, 2017). Captors often mentally restrain victims and prevent them from seeking help even if rescue is offered. According to Baldwin et al. (2011) victims reported traffickers commonly hovered (instilling fear) and translated for the patient (Baldwin et al., 2011). In their recommendations, survivors requested healthcare providers observe patient body language and visual cues of trafficking. Victims also suggested interviews be conducted in

private, away from captor influence, and in the preferred language of the patient (Baldwin et al., 2011). This project prioritizes victim needs and seeks to promote patient autonomy by eliminating disclosure barriers. Thoughtful consideration of stakeholder values and ethics throughout this project will secure adherence to the project vision and commitment to success.

4. Implementation Plan

This project will be implemented using the Model for Evidence-Based Change which suits the proposed problem by providing a systematic six step progression (Dang et al., 2015, p. 287- 289). By incorporating quality improvement principles and collaboration, the Model for Evidence-based change will facilitate interdisciplinary teamwork and improve project potential (Dang et al., 2015, p. 287- 289). This model includes six steps which have been divided into three project phases. Implementation will occur systematically, and each phase will have a specific timeline for execution. The evidence phase, which will take two weeks, involves the collection of internal and external evidence. The design phase which includes establishing practice change, staff engagement, and finalizing the pilot is expected to take five weeks. The implementation phase, expected to take five weeks, includes staff education, implementation of the screening tool, and evaluation of project outcomes. The site for implementation is in the Emergency Department and the screening process will take place privately during the nurse's initial assessment. A flowchart of the implementation process (Appendix B) and weekly timetable (Appendix C) were created to ease applicability.

Phase 1-Evidence

The first phase timeline will be expedited to two weeks due to prior establishment of the clinical question and evidence synthesis. This phase includes evaluating the need for change, locating evidence and critically analyzing evidence. In order to successfully build a case for

change one must have numerical representation supporting the problem at hand. Initially, this requires a retrospective view of data. Internal data collection will focus on disproving the effectiveness of the current process. This is completed through collection of preliminary data, external and internal data comparisons, identification of stakeholders, current practice analysis and barrier examination (Hockenberry et al., 2015, p. 211). Data collection requires identification of systems currently in place at the facility to screen human trafficking victims. Data will focus on the quantity of identified victims (prior to implementation) and the characteristics of this population (chief complaint, ethnicity, age). This data, collected from the electronic health record (EHR), will be compared to statistical estimates of victims seeking treatment in the ED to support predictions that the current screening system is missing victims. To highlight employee knowledge deficits regarding the recognition of human trafficking victims, the team will disperse a survey/questionnaire built into the online educational module.

Another component of evaluating change in the Model for evidence-based practice is establishing stakeholder buy-in. This will be executed with a presentation which provides the background of the problem using statistical evidence, outline of implementation, educational plan, data measurement, and timeline. An essential requirement for project implementation is interdisciplinary representation. The disciplines selected will each play a critical role in project implementation, execution, or evaluation of the clinical question. Team members needed include a social worker, an emergency department (ED) nurse, an ED psychiatrist, an ED physician, a nurse educator, a victim intervention personnel representative, and a nursing data analyst. The inclusion of diversified roles within the team allows for a collaborative approach and promotes quality, safe, patient centered solutions (Persily, 2013, p. 424). The gatekeeper, who's consent is necessary for project advancement, will be the ED director and vice president.

Identified allies include the ED associate director and nursing data analyst. Both colleagues have experience in evidence-based practice implementation and can help assess and eliminate barriers (Hockenberry et al., 2015, p. 206).

After establishing stakeholder buy-in the next step involves evaluating the current screening process. This includes identification of barriers to implementation and linking the problem to outcomes. Potential barriers to implementation include staff beliefs on the importance of the clinical issue, disruption to established workflow, limited resources, and inadequate knowledge of human trafficking contributing to non-compliance (Hockenberry et al., 2015, p. 209). Peer discussion groups and GEMBA walks will be employed to combat these barriers. Informal leader input will be assessed through peer discussion groups and GEMBA walks will identify staff perceptions of change as well as assess comprehension (Hockenberry et al., 2015, p. 215). The potential outcomes of implementation are increased trafficking victim identification.

The next step in planning is external evidence collection. This step has already been completed and summarized into an evidence table (see Appendix A). Steps in this process included identification of sources, review of research concepts, and formulation of a search plan. Step 3 also included evidence appraisals, evidence synthesis, and assessment of evidence for feasibility. Once all internal and external information has been summarized and organized, the design phase can begin.

Phase 2-Design

The design phase of implementation will include elimination of barriers, engagement of staff, and the development of tool and pilot process (Hockenberry et al., 2015, p. 211). The first step in this phase is defining the proposed change. The proposed change is outlined in the

previously established PICOT question: In patients presenting to emergency department (P) how does employee education and implementation of a human trafficking screening tool (I) compared to no use of a screening tool (C) affect the number of identified victims (O) in a two-month period (T)? The next step involves identification of necessary resources. These include cost, time, personnel and workflow disruptions. This project has low resource utilization which is beneficial for buy-in. There is no cost to implement. Personnel needed includes IT, social work, nurses, emergency department educators, and victim intervention personnel. This project will prolong the current nurse psychosocial screening by adding red flags and modifying the screen to include human trafficking questions. This workflow disruption is minimal and expected to take 2-3 more minutes. The next step is development of pilot plans and evaluation of pilot.

The pilot involves modification of the current screening tool in EPIC. Meetings with IT will occur during this time to review changes and test the process. The human trafficking screening will be loaded to EPIC as a part of the initial questions completed during the nursing assessment. In addition to trafficking specific questions, the tool will ask nurses if the patient is alone, if an interpreter was needed/present, and if the patient is exhibiting any red flags associated with trafficking. If the threshold for trafficking is met (>3 red flags) or If a “yes” is answered to the screening question an electronic flag will be generated. This flag will automatically page the victim intervention team through EPIC for further evaluation. The final step of the design phase will focus on finalizing and obtaining approval for pilot (Hockenberry et al., 2015, p. 211).

Phase 3- Implementation

The implementation phase will include the dissemination of human trafficking education to staff. Educational sessions will be provided in a lunch-and-learn format and loaded online in

the educational database. The online module, produced by the SOAR campaign, credits employees with one CE upon completion and will require completion one week prior to pilot (Department of Health and Human Services [DHHS] & Office on Trafficking in Persons [OTIP], 2020). To promote engagement, trafficking materials such as badge buddies, pamphlets, and posters (example of materials in Appendix D) developed by Department of Homeland Security Blue campaign will be distributed throughout the department. After finalizing the pilot design and implementing education, the tool can be implemented.

Step five, pilot implementation, (expected to last three weeks) includes operationalizing practice changes, evaluating outcomes, and refining processes (Hockenberry et al., 2015, p. 211). During this time the screening tool will go live in the EHR. To promote compliance, IT staff and project team members will be rounding on the unit to answer questions and monitor for glitches. During the first week of implementation the project team will communicate with the ED daily via email. Emails will brief the department on any issues and answer frequently asked questions. Weekly progress updates will be sent via email to stakeholders. Throughout implementation data will be evaluated to determine if the process is increasing identified victims of human trafficking. The process of evaluating outcomes and refining the process is discussed below.

5. Data Collection Methods

Data collection and analysis is required throughout project implementation. Data will determine if implementation measures are successful and sustainable (Stevens, 2015, p. 83). Preliminary internal data, obtained from the EHR, will be retrospectively collected from 6-months prior to implementation date. Data obtained from the EHR includes the quantity of identified victims and the characteristics of this population (chief complaint, ethnicity, age). Data collection upon pilot launch will also be extracted from the EHR. Analysis will include

demographic characteristics of victims (chief complaint, ethnicity, age). EHR data will be reviewed and evaluated for compliance with the screening process. This data will be collected through chart auditing. Compliance is expected to be at 80% by second week of implementation (Egyud et al., 2017). It is also important to analyze the incidence of victims identified along with the sensitivity, specificity, positive/negative predictive value of the screening tool, and red flag indicators. Based on literature review, prevalence of human trafficking victims in the emergency department is approximately 5-10%. Based on current volume, it is expected the screening identifies six patients per day (Chisolm-Straker et al., 2019; Egyud et al., 2017; Greenbaum et al., 2018; Kalisto et al., 2017; Mumma et al., 2017). Although a 10% positivity rate would be ideal, any improvement in identified victims will be meaningful. For the screening tool to be considered clinically significant, confidence intervals are expected to be >95%, sensitivity >80%, specificity >60%, and as other studies demonstrated a NPV of >80% is the goal (Chisolm-Straker et al., 2019; Egyud et al., 2017; Greenbaum et al., 2018; Kalisto et al., 2017; Mumma et al., 2017).

The Likert scale will be used to collect and analyze data regarding the effectiveness of the educational intervention. This evaluation tool (located in Appendix D) has been adapted from Berishaj et al. (2019), a study which measured victim identification confidence after a human trafficking educational conference. The questions have been slightly modified to best suit this project. The survey is 10-questions and responses range from strongly disagree (1) to strongly agree (5). The identical pre/post surveys will be embedded into the online training module. The pre-test will populate immediately prior to education. Completion is required to proceed. The post-test is required to obtain certificate of completion and populates automatically after training module is finished. Mandatory completion will help attrition rate. Results of the

surveys will be anonymous. Scores of the survey will be analyzed using pre/post test means, standard deviation, and paired t-tests. Based on literature, the educational intervention will be successful if $p<0.05$ from pre-test to post-test. A p-value of <0.05 indicates the null hypothesis (education intervention is ineffective) is not likely to occur, indicating clinical significance (Berishaj et al., 2019; Donahue et al., 2019; Pilot & Beck, 2017 p. 445). Incidence trends and compliance rates will be graphed and sent to staff for weekly review. The number of victims identified pre-implementation will be compared to the number of victims recognized post-implementation to determine if the intervention is effective.

6. Cost/Benefit Discussion

A benefit to the proposed change-based intervention is low cost and limited resource utilization. The proposed epic changes can be completed in a day and cost the hospital nothing. The human trafficking online education module provided by the SOAR project is also free of charge and complies with state legislative requirements for human trafficking continuing education (DHHS & OTIP, 2020). The module will be uploaded into the employee education portal by a nursing educator and can be completed while at work, thus eliminating the need to pay for education time. All resource materials provided by the Blue campaign (posters, pamphlets, badge buddies) are free of charge. There are no identified ongoing costs related to project implementation. On a larger scale, in 2018, the United States spent nearly $27 million dollars in funds combating human trafficking nationally (DHHS & OTIP, 2020). Carpenter and Gates (2016) discovered the alarming scope of trafficking revenue within San Diego county, estimating facilitators of sex trafficking had annual incomes exceeding $670,000, and the illegal sex economy was valued at approximately $810 million dollars. With the accumulation of evidence supporting the scope of human trafficking, the CDC (2019) released new ICD-CM

codes (effective October 1st, 2020) related to trafficking conditions. These codes will help government agencies more accurately estimate the healthcare costs of human trafficking. This evidence further supports implementation because patients cannot be coded for human trafficking conditions if victims are not recognized. More sensitive screening measures can positively impact hospital reimbursement and contribute to prevalence data. Potential cost savings and promotion of patient safety support implementation.

7. Discussion of Results

This benchmark project is a proposal for implementation; therefore, no results have been generated. This project consists of several measurable outcomes that will clearly define project success. Outcomes which can be measured include compliance with screening tool, effectiveness of a screening tool, and employee confidence in identifying victims. Communication of project results is a key component of maintaining engagement and change management. Results will be graphed showing project progression and sent to staff weekly. Although there is no data to report, the preliminary acceptance of change is promising. The team is committed to the vision and all stakeholders remain engaged. The success of the project thus far is favorable and by methodically following evidence-based practice change models the plan is organized and ready for approval.

8. Recommendations

It is recommended the following four measures be implemented to improve trafficking victim recognition and promote patient safety. These measures are supported by evidenced-based practice and align with Joint Commission guidelines. First, psychosocial screening should take place in a private enclosed room with just the patient and healthcare worker (Baldwin et al., 2011). This revision will enhance patient comfort, help establish trust with the healthcare

worker, and promote patient autonomy. The second implementation measure will require use of a certified medical interpreter for screening if the primary language is not English (Baldwin et al., 2011). This addition to the process will prevent coercion or confusion with screening questions. The third recommended intervention is addition of a screening question specifically targeted at identifying victims of trafficking. The proposed question is "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?" (Mumma et al., 2017). This question will expand the screening population and create a larger safety net. The next change includes the integration of red flag documentation in the screening questionnaire. This "select all that apply" click box will que the provider to determine if the patient has common complaints or behaviors frequently seen in victims of domestic violence, human trafficking, or sex trafficking (Egyud et al., 2017). The final change of this benchmark project is requiring employee completion of an online human trafficking education module. Implementation of these measures will promote disclosure of victim status by creating a safe environment and screen for victims of human trafficking. These measures will be systematically implemented over 12 weeks using the Model for Evidence-Based Change. Data will be collected and methodically evaluated. Depending on data and feedback the process may be adjusted.

Conclusion

Human trafficking is a global health concern which requires diligence in both assessment and recognition of potential victims. Parkland's current psychosocial screening process fails to recognize victims of human trafficking, thereby preventing opportunities for rescue. Furthermore, the screening neglects the safety of victims by failing to remove barriers which prevent abuse reporting. Evidence supports implementation of a trafficking screening tool, red

flag assessment, and elimination of potential barriers to reporting in order to optimize victim recognition. The proposed measures will enhance recognition and rescue human trafficking victims. In turn, this well set a precedence for hospitals throughout the country.

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Appendix A

Synthesis Table

Evaluation Table Template

PICOT Question: In patients presenting to emergency department triage (P) how does employee education and implementation of a human trafficking screening tool (I) compared to no use of a screening tool (C) affect the number of identified adult victims (O) in a two-month period (T)?
PICOT Question Type (Circle): Intervention Etiology Diagnosis or Diagnostic Test Prognosis/Prediction Meaning

Caveats

1) The **only studies** you should put in these tables are the ones that **you know answer your question** after you have done rapid critical appraisal (i.e., the keeper studies)
2) Include APA reference
3) Use abbreviations & create **a legend** for readers & yourself
4) Keep your descriptions brief – there should be **NO complete sentences**
5) This evaluation is for the purpose of knowing your studies to synthesize.

Place your APA Reference here (Use correct APA reference format including the hanging indentation):

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	Conceptual Framework	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**How did you get the Data Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])**

Citation: (i.e., author(s), date of publication, & title)								
Author, Year, Title	**Theoretical basis for study Qualitative Tradition**		**Number, Characteristics, Attrition rate & why?**	**Independent variables (e.g., IV1 = IV2 =)** **Dependent variables (e.g., DV =) Do not need to put IV & DV in Legend**	**What scales were used to measure the outcome variables (e.g., name of scale, author, reliability info [e.g., Cronbach alphas])**	**What stats were used to answer the clinical question (i.e., all stats do not need to be put into the table)**	**Statistical findings or qualitative findings (i.e., for every statistical test you have in the data analysis column, you should have a finding)**	• **Strengths and limitations of the study** • **Risk or harm if study intervention or findings implemented** • **Feasibility of use in your practice** • **Remember: level of evidence (See PICOT handout) + quality of evidence = strength of evidence & confidence to act** • **Use the USPSTF grading schema http://www.ahrq.gov/clinic/3rduspstf/ratings.htm**
Berishaj et al., (2019) The impact of an educational intervention on the knowledge and beliefs of registered nurses regarding human trafficking.	None	Descriptive Quantitative-pilot (quasi-experimental)	*n*=93 Age 25-54yo 98.9% female, 1 male participant 94.6% (88) Caucasian 33.3% > 20+ years of nursing experience 24.7% 1-5 years of nursing experience 79.6% (74) work in a hospital 69.9% no prior hx of	IV: EE DV: K&B r/t HT	19 item survey tool given pre/post intervention	t-tests pre/post Identify +ST t= Identify +HT t= Assist victims t= Resources to assist t= Make a difference t=	 -14.352 -13.403 -14.134 -14.142 -3.848	Strengths: Significant t-test results on 17/19 questions indicating intervention was successful. Highly reliable survey tool. Statistically significant results produced. Produced further evidence that educational intervention improves perceptions of knowledge r/t HT. Limitations: Limited generalizability due to demographics of those in attendance (Caucasian females). Small sample. Unsure if this educational intervention directly impacts the # of HT victims identified. Risk of Harm: None Feasibility: This educational intervention is not feasible as a conference cannot be arranged within proposed time frame. This study further demonstrates that educational interventions positively improved confidence in treating and recognizing victims of human/sex trafficking. Additionally this pilot provided measurement tools and survey questions to assess knowledge which can be utilized. Level of Evidence: 6

			HT education Attrition: none					LOC: Moderate USPSTF: C
Greenbaum et al., (2018) Short screening tool to identify victims of child sex trafficking in the health care setting	None Stated	Cross-sectional observational study	*n*=108 from 3 ED or CP clinic CST: *n*=25 ASA*: n=8*2 Avg Age of CST 15.4 CST: 100% Female CST: 72% African American English Speaking only 48% CST victims had tattoos 96% CST were sexually active No attrition identified	IV1: CST victims IV2: ASA victims DV: S&S of screening questions	Wilcoxon Rank Sum Test X^2 2-sample t-test Multivariable logistic regression models AUROC	S & S PPV NPV	2+?'s 92% 3+?'s 84% 4+?'s 56% 5+?'s 24% 2+ 73% 3+90% 4+98% 5+100% 2+ 51% 3+72% 4+88% 5+100% 2+97% 3+95% 4+88% 5+81%	Strengths: Highlighted key differences in demographics and presentation of CST vs ASA Strong realism. Evidence shows reliability of 6 item screening tool, good feasibility. Limitations: Small sample size small and only in 1 southern metroplex, no males identified, limited to English speakers. Population is 18 and < therefore questions might need to be adjusted to meet my pt population needs. Exclusion criteria affected involved demographics. Weak ability to support casual inferences. Limited generalizability Risk of Harm: None Feasibility: identified risk factors could be applied to the adult population, aside from sexual hx, limiting non English speaking patients does not include a majority of my patient population. I will use this evidence to demonstrate the need for a screening tool which combines risk factors and screening questions which is SEPARATE from a domestic violence screening. Level of evidence: 4 LOC: Moderate UTSPF: B
Gerassi et al., (2018) Examining commonly reported sex trafficking indicators from practitioners' perspectives:	None stated	Descriptive Quantitative-pilot study	*n*=86 providers to HTV located in 1 city 72% female 19/86 HCP	IV: Survey response DV: HT indicators	Results of indicator survey	Indicator Means Mental Health Physical Health	 All:3.05 US Adults: 3.07 Foreign Adults: 2.12 All: 2.67 US Adults: 2.65 Foreign Adults: 2.66	Strengths: Provides insight into the HCP perceived indicators of human trafficking which could improve recognition. Determines that mental health complaints are commonly seen in victims of human trafficking. Study highlights that overt signs of trafficking might not been seen and other indicators could also be useful. Limitations: Small sample size, limited recruitment region, pilot included non healthcare

Findings from a pilot study			72% (*n* = 62) with U.S.-born adults, 24% (*n* = 21) with foreign-born minors 35% (*n* = 30) with foreign-born adults.			Behavioral Health Variables 2+s/s depression Low self esteem anxiety	All: 2.64 US Adults: 2.62 Foreign Adults: 2.76 3.82 3.59 3.55	participants. Not based on direct victim information. Risk of Harm: None Feasibility: This study can be referenced when creating red flags for employee education and screening tool. LOE: 6 LOC: Moderate UTSPTF: C
Greenbaum et al., (2018) Evaluation of a tool to identify child sex trafficking victims in multiple healthcare settings	None stated	Cohort Observational Study	*n*=810 from 16 facilities 91 from ED Ages 11-17 Average Age 14.6 English speaking only CC of sexual violence 84.3%F 11.1% CV ST (13.1% in ED) 18.2% Hispanic 27.5% Black Attrition=12.9% or 91 pts d/t no response or unsure response	IV: CST victims DV: S&S of screening questions	17 ? self report questionaries'	%, p-value of screening questions Sensitivity Specificity NPV PPV	83.3% + hx of STI ((<.001) 66% +drug Etoh use (<.001) 74% hx of running away (<.001) 83.3% of CSTV 2+ positive screening questions 84.4% (CI 95% 75.3-91.2) 57.5% (CI 95% 53.8-61.1) 96.7% (CI 95% 94.6-98.2) 19.9% (CI 95% 16-24.3)	Strengths: Significant amount of data collected such as demographics and chief complaints. Strong realism. Evidence shows reliability of 6 item screening tool, good feasibility. Large sample from various facilities. Limitations: Sample was limited to English speakers, Wide CI for sensitivity. Exclusion criteria affected involved demographics. Weak ability to support casual inferences. Risk of Harm: None Feasibility: Although the identified risk factors do not apply to a majority of my patient population, I will use this evidence to demonstrate the need for a screening tool which combines risk factors and screening questions. Implementation process should be replicated in my project and evaluated using the same statistical measures. This evidence SHOULD be included in employee education to highlight concern when multiple risk factors are present in pediatric patients. Level of evidence: 4 LOC: Moderate UTSPF: B

Baldwin et al., (2011) Identification of human trafficking victims in health care settings	Grounded Theory	Descriptive Qualitative	*n*=12 HT/ST victims Age 22-63, all F 10 different countries 50% of HTV were seen by HCP Attrition=0	IV: HCI of CV DV: Themes from statements	Semi structured victim interviews Exploratory pile sorting Framework analysis Separation into domains, themes and subthemes	HCI CC of HT CC of STV Barriers to disclosure Payment Other # of CV who were asked about trafficking	Varied settings illness preventing performance STI trmt , Pregnancy tests & abortions Trafficker stayed in close proximity Spoke English and acted as translator Fear and Shame Coached on lies to tell Paid in cash Delays btwn onset and visit to doctor 0, all denied being questioned by HCP about safety	Strengths: Provides insight into the barriers and facilitators to victim identification, information was collected from women all over the world who spoke different languages, identified common complaints. Limitations: Small sample size, limited recruitment region, specifically foreign victims, only female. Difficult to make generalizations. Risk of Harm: None Feasibility: Will require screening to be done in language of preference with only the patient in the room, will include common red flags to help in recognition LOE: 6 LOC: Moderate UTSPTF: C
Chisolm-Straker et al., (2019) Screening for human trafficking among homeless young adults	None	Prospective Cohort	*n*= 307 Homeless adults 18-22yo Average age 19.5 <20% white 1.6% transgender 8.8 % CV 66.7%+ST 46.7% +HT 16.7% +HT+ST Attrition=0	IV: QYIT ST DV1: S&S of questions DV2: CV	Results of QYIT screen HTIAM-14 results	QYIT >1 S & S PPV, NPV QYIT>2 S & S PPV, NPV QYIT>3 S & S PPV, NPV QYIT of 4 S & S PPV, NPV Odds ratio+CI	86.67% 76.45% 26.26%, 98.34% 56.67% 95.81% 56.67%, 96.81% 40.0% 99.68% 92.31%, 94.50% 23.33% 100% 100%, 93.09%	Strengths: Large sample, tool is brief and highly sensitive, QYIT was compared to another validated tool. Does not require specialized HT experience or training for administration. Limitations: limited to homeless who were seeking assistance, population was mostly non white therefore populations who have predominately white may not have similar results. Not validated in ED. Risk of Harm: None Feasibility: Can use for a portion of population, questions will be compared to other studies for sensitivity in use of screening tool, not validated for adults >22yo. LOE: 4 LOC: Moderate UTSPTF: B

						Question 1 Question 2 Question 3 Question 4	10.48 CI (4.010-27.37) 14.17 CI (3.815-52.64) 28.24 CI (7.169-111.2) 1.375 CI (0.392-4.701)	
Donahue et al., (2019) Educating emergency department staff on identification and treatment on human trafficking victims	None	Descriptive quantitative	*n*=75 ED employees 66% nursing staff >2years experience 2 Suburban PA Hospitals Attrition rate: 25% Why? Non-response error	IV: OTM DV1: understanding of HT DV2: Confidence in HTVI DV3: usefulness of OTM	Pre-post education surveys within OTM LIKERT Scale questions	% Pre-OTM HT EE %Understanding of HT Pre-OTM Post-OTM Confidence in HTVI Pre-OTM Post-OTM % usefulness of OTM	11% 49% 94% 4/10 7/10 92%	Strengths: Identifies the need for standardized education, demonstrates that EE and an OTM increase employee confidence in victim recognition and treatment. Employees find OTM useful. Study is a good guide for implementation of HT training. Limitations: Small sample size. Limited results reporting. Did not include demographics of participants. Did not give results of identified victims of HT. Non-response error, creating an attrition of 25%. Data was self reported and subject to bias. High incidence of HT in study area employees might have had previous exposure to topic. Using confidence measurement created potential social disability bias. Did not use a knowledge based quiz. Risk of Harm: None identified Feasibility: Will use a pre and post survey to determine EE confidence. Will use an OTM to educate staff. LOE: 6 LOC: Moderate USPTF: C
Kaltiso et al., (2018) Evaluation of a screening tool for child sex trafficking among patients with high-risk chief complaints in a pediatric emergency department	None Stated	Prospective Observational Study-descriptive	*n*=203 11 CST victims mean age 15.9 years old 100 (49%) + screen 9F, 2M 55% seen a HCP within 6mo	IV1:Demographics & clinical characteristics IV2: # of ST ? DV1: CST DV2: S&S of tool	Wilcoxon Rank Sum Test Fishers Exact Test X^2 Screening tool Criteria	+CHT Prevalence 2+ answers S & S PPV NPV False -	+CST: 5.4% (95% CI = 2.88%–8.9%). 90.9% (CI 95%) 53.1% (CI 95%) 10.0% (95% CI = 5.0%–17.6%) 99.0% (95% CI = 94.7%– 99.9%)	Strengths: Significant amount of data collected such as demographics and chief complaints. Strong realism. Study identified victims that would not have been detected without questions, utilized preferred trauma informed approach. Limitations: Small convenience sample from single facility, conducted by researcher not ED staff. Small identified +CST victims. Wide CI for sensitivity. Exclusion criteria affected involved demographics. Weak ability to support casual inferences. Risk of Harm: None identified Feasibility: +NPV, and sensitivity indicated for post implementation data analysis to determine correlations.

			Inner city PED attrition rate:none			False+ 3+answers S & S CC	9.1% (95% CI = 1.62%–37.7%) false- negative rate, and 46.9% (95% CI = 40.0%–53.9%) false-positive rate. 75.5% (68.8%-81.4%CI) 81.8% (58.2%-97.7%CI) 45% “behavioral complaints”	LOE: 6 LOC: Moderate USPTF: B
Bespalova et al., (2016) A pathway to freedom: An evaluation of screening tools for the identification of trafficking victims	None Stated	Qualitative: Literature Review	*n*=9 4 adult ST 4 adult + children 1 children # of ?’s >100 (2), <50 (3) <15 (4) Attrition rate: none	IV1: Properties of HTM IV2: Characteristics of HTM DV: HCA HTM	No measures	Synthesis Tables (2) Prop of HTM: Demographic # of ?’s HCA HTM Characteristic Of HTM: Validity Reliability Recommendations:	 Demographic- Adults (4) Adults+Children (4) Children (1) # of ?’s >100 (2), <50 (3) <15 (4) HCA HTM (2) 1 1 PPMAT (6?’s, HCA, HTM)	Strengths: Study identifies important literature gaps, critically appraises screening tools, review is organized, review supports need for new study & draws reasonable conclusions regarding practice implications. Limitations: Limited by length of search, used search terms and data bases searched, lack of literature on topic. No tools found using academic database. Study findings inconsistent/varied. Some tools >3 years old. Risk of Harm: None identified Feasibility: feasibility in using study to guide HT screening tool selection. RCA suggest potential bias in lack of stated study designs and varied results. Level of Evidence: 7 LOC: Moderate: USPSTF: B
Egyud et al. (2017) Implementation of human trafficking education and treatment	Johns Hopkins Nursing EBP Model Everett M. Rogers	Quantitative, descriptive EBP project	*n*=102 (responses to survey) *n=38* (sex trafficking victims)	IV1: MRF IV2: SN IV3: EE DV1: +ST DV2: STC	Anonymous Survey (all ED staff) 5month post-implementation EHR audit	%STC %ECTC %EC +ST, PTI +ST %MRF	97% *(n* = 99) 74% *(n* = 76) 100% 0 38 53% 20pts	Strengths: Thorough and mandatory education process, length of audits is appropriate, +results, 100% compliance, strategic implementation plan Limitations: unable to measure if all victims who presented were identified. Blue dot is not traceable and many participants did not follow

algorithm in the emergency department	Change Model		ED Staff (MD, RN, Ancillary) Level II Trauma Center in PA No attrition		Department of HHS screening tool for human trafficking No information provided on survey	%SN	47% 18pts	through, lack of tracking victims PTI. Study is vulnerable to selection threat, weak support for casual inference Risk: None identified Feasibility: Education implementation methods feasible, RCA suggests consider EPB evidence with caution, SN process may be complicated with current work flow LOE: 6 LOC: Moderate USPSTF: B
Dols et al., (2019) Human trafficking victim identification, assessment, and intervention strategies in south Texas emergency departments	None	Descriptive quantitative study	*n=27* Setting: EDs in 5 South Texas TSA 21 BC STRAC:7 ACS:7 Leaders in ED Attrition: none	IV1: ED HTM Adults IV2: ED HTM Children DV1: Screen for AHT DV2: Screen for CHT DV3: CV	23 question survey (online, email and phone)	% of response % AHT Location HCW CV %CHT Location HCW CV % AHT&CHT HTMA: HTMC:	27% 40.7% During Triage (55.6%) RN (66.7%) 0 37% During Triage (48.1%) RN (63%) 0 25% Triage Questions regarding Safety (36.4%) Abuse/Fear Question (18.2%) Safety Screening (20%) Triage Questions (20%)	Strengths: Strong in realism, applicability, good data collection, significant population representation, s Limitations: Does not support casual inferences, selection bias, Low Response Rate, Convivence sampling, leader response, lack of contextual information, regional focus. Risk: None identified Feasibility: Can be used to determine need for standardized tool, highlight lack of standardization and ineffectiveness. This study determined who most likely completed the screening. LOE: 6 LOC: Moderate USPSTF Grade: C
Mumma et al. (2017) Screening for victims of sex trafficking in the emergency department: A pilot program.	None	Descriptive-quantitative study	*n=146* md age 27 100% F Setting: 1 academic ED with >70,000 annual visits Attrition: none	IV1: SS IV2: PC DV1: Identified ST Victims DV2: FOS	14-question screening survey based on published recommendations: not validated	Total +ST CV CI #PC (%, CI) Vs. #SS (%, CI) Vs. #PC+SS (%, CI)	46 10 (75, 95% CI [15%-29%] 7/46 (7% PC, 95% CI) 30/46 (21%, 95% CI) 9/46 (6%, 95% CI)	Strengths: High rate of true positives, identified single question with 100% yes with ST victims, identified feasibility of implementation and low sensitivity to identify by just PC. Limitations: potential for lack of identification d/t false negative screens or dishonest answers to questions Not validated in ED Small Sample Size, convivence sample No long term follow-up

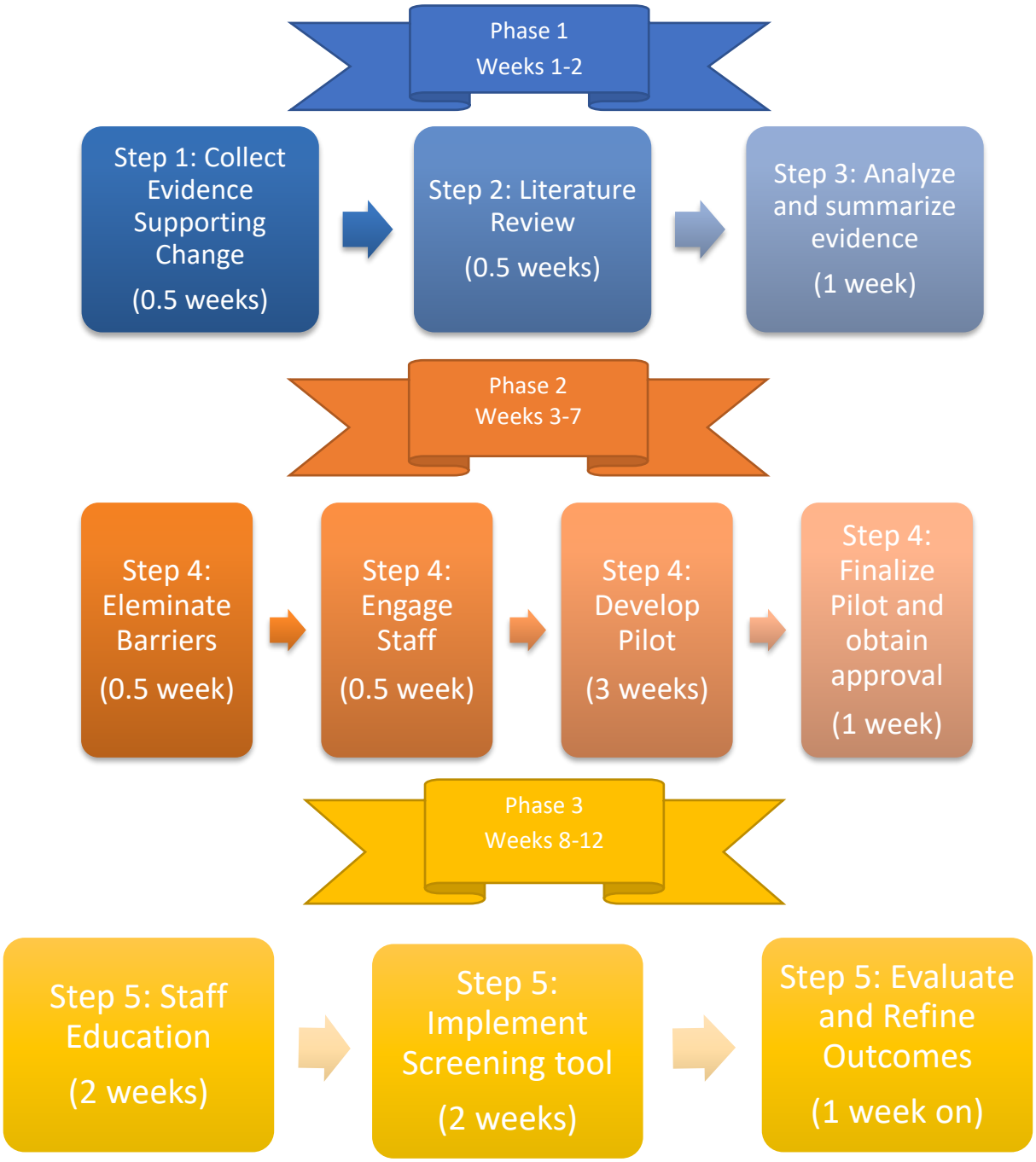
						S & S	100% SS 40% PC 78% SS 91% PC	No information provided if MD participants were aware of study Risk: None identified Feasibility: Use to determine the need for a screening tool to identify victims of ST LOE: 6` LOC: low USPSTF Grade: D

Legend:
ACS: American college of surgeons trauma designation
ASA: Acute Sexual Assault
AHT: Screen for Adult Human Trafficking
BC: Border Counties
CC: Chief Complaints
CHT: Screen for Child Human Trafficking
CP: Child Protective
CST: Child Sex trafficking victims
CV: Confirmed victims of trafficking
EC: Employee Compliance
ECTC: Employees committed to change
ED: Emergency department
EE: Employee Education
F: Female
FOS: Feasibility of Survey
HCI: Healthcare Interactions
HCP: Health Care providers
HCA: Health Care Appropriate
HTM: Human Trafficking Screening Methods
HTVI: Human Trafficking Victim Identification
K&B: Knowledge and Beliefs
Md: Median

MRF: Medical Red Flags
NPV: Negative Predictive Value
OTM: Online training module
PC: Physician Concern
PC+SS: Physician Concern & Survey Screening
PED: Pediatric Emergency Department
PPAT: Polaris Project Assessment Tool
PPV: Positive Predictive Value
PTI: Prior to intervention
SN: Silent Notification
SS: Survey Screening
S&S: Sensitivity and Specificity
ST: Sex Trafficking
STC: Sex Trafficking competence
STRAC: Southwest Texas Regional Advisory Council
+ST: Victims of sex trafficking
TSA: Trauma Service Areas

***Prompts for each column – **please do not repeat the headings, just provide the data**

Appendix B


Phase 1
Weeks 1-2
Step 1: Collect Evidence Supporting Change
(0.5 weeks)
Step 2: Literature Review
(0.5 weeks)
Step 3: Analyze and summarize evidence
(1 week)
Phase 2
Weeks 3-7
Step 4: Eleminate Barriers
(0.5 week)
Step 4: Engage Staff
(0.5 week)
Step 4: Develop Pilot
(3 weeks)
Step 4: Finalize Pilot and obtain approval
(1 week)
Phase 3
Weeks 8-12
Step 5: Staff Education
(2 weeks)
Step 5: Implement Screening tool
(2 weeks)
Step 5: Evaluate and Refine Outcomes
(1 week on)

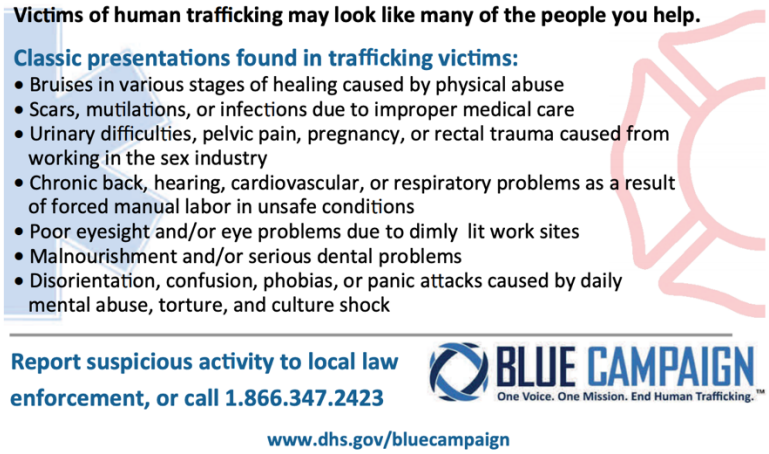
Appendix C

Timetable

Calendar Weeks	1	2	3	4	5	6	7	8	9	10	11	12
Evidence Phase												
Evaluate Need for Change: Collect Evidence Supporting Change												
Locate Best Evidence: Literature Review												
Critically Analyze and Summarize Evidence												
Design Phase												
Eliminate Barriers												
Engage Staff												
Develop Pilot												
Finalize Pilot/ Obtain Approval												
Implementation Phase												
Staff Education												
Implement Screening Tool												
Evaluate and Refine Outcomes												
Calendar Weeks	1	2	3	4	5	6	7	8	9	10	11	12

Appendix C

Education Materials



Images retrieved from Blue Campaign website (U.S. Department of Homeland Security, 2020)

Appendix C: Continued

Images retrieved from Blue Campaign website (U.S. Department of Homeland Security, 2020)

Appendix D

Evaluation Instrument

Human Trafficking Education Module	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I understand the difference between labor and sex trafficking	1	2	3	4	5
I understand the difference between prostitution and sex trafficking	1	2	3	4	5
I understand men can be victims of human trafficking	1	2	3	4	5
I understand risk factors of human trafficking victims	1	2	3	4	5
I am confident in my ability to identify a victim of human trafficking.	1	2	3	4	5
I am confident in my ability to assist a victim of human trafficking.	1	2	3	4	5
I understand mandatory reporting processes related to human trafficking.	1	2	3	4	5
I am aware of resources to assist human trafficking victims.	1	2	3	4	5
I can make a difference in the fight against human trafficking.	1	2	3	4	5

Evaluation tool adapted from Berishaj et al., 2019