Creating Buy-In from Nurse Leaders to Implement Inpatient Education and Screening for Human Trafficking: A Quality Improvement Initiative

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Creating Buy-In from Nurse Leaders to Implement Inpatient Education and Screening for Human Trafficking: A Quality Improvement Initiative

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Human trafficking is a social evil that must be eradicated. Nurse leaders and the nurses they guide have the ability to help end this crime against humanity. It is with extreme humility that I offer this academic work as a source of evidence and a source of knowledge that can be used to continue work that I am passionately committed to.
Abstract

BACKGROUND: Human trafficking is an under-recognized healthcare issue affecting an estimated 20 to 40 million individuals globally. Professional nursing organizations, healthcare regulatory bodies and legislators have declared the need for education and screening practices. A quality improvement initiative designed to create buy-in from nurse leaders to create and implement education, screening and a protocol to guide care of human trafficking victims who may present to inpatient and clinic settings at the organization was developed to bridge gaps in knowledge and inform evidence-based practice.

METHODS: Literature review informed the development of an education intervention presented to nurse leaders using multi-modal learning strategies. National Academy of Medicine criteria for safe, high quality, patient-centered care was used to determine need for the quality improvement initiative. Victimology paradigm guided development of the content and the educational initiative was implemented using a framework recommended by subject matter experts Miller, Chisolm-Straker, Duke and Stoklosa (2019). A brief educational intervention was deployed in effort to engage a voluntary participant group of 191 nurse leaders with purpose to create endorsement for policy and practice change.

INTERVENTION: Brief education about human trafficking and the need for education, screening and a protocol to guide care was deployed to the participant group using multi-modal strategies. Pre and post assessment surveys were conducted to detect any changes in knowledge about human trafficking as a healthcare issue and any changes in attitudes related to implementation of standardized education and screening practices with a protocol to guide care of victims.
RESULTS: Data was analyzed using two statistical methods for increased understanding of results. The primary statistical analysis method, a two-tailed student’s t-test assuming unequal variances found statistical significance for four of the eight survey items. Three knowledge questions and one attitude question evidenced a statistically significant increase in knowledge and support related to the quality improvement intervention. Two attitude questions related to support for education and screening for human trafficking evidenced near statistical significance. The secondary statistical analysis method, randomized and equal sized samples, yielded no statistical significance for any of the survey items. Significant differences in response rates to the pre and post assessment surveys along with homogeneity of the target population may have impacted the results of data analysis.

CONCLUSIONS: The quality improvement initiative demonstrated some ability to meet all of identified aims. Statistical significance was noted for a number of survey items, but the primary focus items, endorsement for education and screening practices for human trafficking, did not achieve statistical significance. Unanticipated tacit knowledge about human trafficking within the participant group along with existing attitudes of support for education and screening for human trafficking may have affected survey results. Despite lack of statistical significance related to nurse leader buy-in for education and screening practices, overwhelming positive feedback from the participant group and support for the quality improvement initiative demonstrated a high degree of clinical significance.

Keywords: human trafficking, education, screening, protocol, nurse leaders
Creating Buy-In from Nurse Leaders to Implement Inpatient Screening for Human Trafficking:

A Quality Improvement Initiative

Problem Description

The Thirteenth Amendment to the Constitution of the United States abolished slavery in 1865. Despite this, in 2020, trading human beings as a commodity is an international crisis. Human trafficking is a modern version of slavery and victimizes human beings for profit (Donahue, Schwien & Lavallee, 2019). The United Nations (UN) defines human trafficking as \textit{the recruitment, transportation, transfer, harboring, or receipt of persons by improper means (such as force, abduction, fraud, or coercion) for an improper purpose including forced labor or sexual exploitation} (National Institute of Justice, 2019). The International Labor Organization (ILO) reports that human trafficking is a $150 billion dollar a year illegal industry and ranks third in terms of profitability, falling behind only the illegal sales of weapons and drugs (ILO, 2019). The Joint Commission (TJC) identifies human trafficking as society’s most rapidly growing criminal industry, the second largest source of financial income for organized crime, and a significant healthcare issue that has not been adequately addressed (TJC, 2018a).

Human trafficking is a grossly unidentified/under-identified problem for healthcare and for society. Estimates indicate that between 21 and 40 million individuals worldwide are victims of human trafficking (Long & Dowdell, 2018, Tracy & Macias-Konstantopoulos, 2018). Nurses have been identified as the most likely healthcare provider to have contact with human trafficking victims (Hachey & Phillippi, 2017). Education of nurses about human trafficking is essential to create effective strategies to screen for human trafficking and provide resources to victims. Studies indicate that as many as 88% of victims of human trafficking engaged with healthcare providers while being trafficked but remained unidentified (Leslie, 2018, Macias-
Konstantopoulos, 2016). Exploitation via human trafficking is a significant determinant of health and general well-being. It must be understood as preventable in terms of its impact on health (Zimmerman & Kiss, 2017). Strategies that focus on identification of victims are essential to efforts aimed at prevention and mitigation of sequelae. These strategies will improve the quality of life for victims of human trafficking and concurrently improve societal conditions by moving towards eradication of human trafficking and its malicious effects (Hachey & Phillippi, 2017).

Victims of human trafficking are at high risk for a myriad of physical and psychological healthcare issues. These healthcare issues often progress rapidly and/or become more complex due to unwillingness of traffickers to allow victims access to care or hesitance of victims to present for care due to fear, shame or other feelings that contribute to avoidance behaviors. Even when access is allowed, victims often mistrust health care providers and may be conditioned through abuse/coercion to avoid full disclosure of healthcare concerns, even when need for help is dire. Unwillingness of traffickers to allow access to healthcare, unwillingness/inability of victims to disclose, and provider failure to detect signs and symptoms (“red flags”) of human trafficking all increase risk for advancement of adverse health conditions and intensify the vulnerability of victims for additional harms (Association of Women’s Health, Obstetrics & Neonatal Nursing [AWHONN], 2016, Beck et al., 2015). Detection of human trafficking is difficult even for experienced clinicians. Standardized education and screening that is sensitive to the special circumstances of victims must be created and implemented as part of mandatory health assessment processes. It is imperative that focus be directed to increasing the quality of care for this population through initiatives designed to improve detection and treatment. The lack of consensus on implementation of a standardized validated screening tool to assess for human trafficking compounds the challenges faced by healthcare professionals caring for victims.
Increasing awareness of human trafficking as a healthcare concern is foundational to increasing detection. A well-designed initiative to educate nurses about human trafficking and screening, including at-risk populations, signs and symptoms, and resource requirement serves to improve the quality of care for this population. Victims of human trafficking are at high risk for harm. Increasing provider knowledge and confidence to identify signs and symptoms of human trafficking will enable providers to implement treatment strategies that reduce harm and improve safety for the individual, the organization, and society at large. Such efforts also support future research on the subject of human trafficking by contributing to the body of knowledge which informs evidence-based practice and enhances victim care and services.

Despite passage of legislation in 2012 that outlawed human trafficking in the state where the initiative was deployed, calls to the National Human Trafficking Hotline to report human trafficking in the state increased by more than 40% from 2012 to 2017 (Sherman, 2019). Human trafficking is growing rapidly as a local industry and a crime. There is a resultant negative impact on the community and its inhabitants. Efforts to enhance detection of victims must be amplified and expanded. The rise in human trafficking brings a concurrent rise in physiological, psychosocial and economic costs to the community which must be averted (Institute for Women’s Policy Research, 2017).

The current curriculum at a large urban academic healthcare organization in the Northeast United States does not provide education about identification and treatment of human trafficking victims for nurses who work outside of the Emergency Department (ED). Although many victims of human trafficking enter the healthcare environment through the ED, many may also enter through other portals, such as clinics, non-emergent procedural areas, and inpatient settings. There are no human trafficking screening practices for inpatients or patients who
receive care in the many ambulatory/outpatient services areas of the organization. It is imperative that all healthcare providers be educated in identification and treatment of human trafficking victims so that high-quality, individualized, patient-centered, problem-focused care can be delivered in an equitable manner. The Institute of Medicine (IOM), now known as the National Academy of Medicine, (NAM) has mandated these criteria for all patient care delivery (Harris, Roussel, Dearman & Thomas, 2016). At present, care for human trafficking victims fails to meet the NAM mandate within the organization. Quality improvement is necessary. A standardized education and screening process are foundational for accurate victim identification and successful treatment of victims. In late 2018, there were two suspected cases of human trafficking identified in inpatient settings at the organization. One case was identified as part of morbidity and mortality (M&M) rounds after the patient had eloped from the hospital. In this case, the trafficker was present with the inpatient victim and created a perceived physical threat to the victim, staff and other patients/visitors which resulted in action by hospital security to avert risk. The other case was identified through consultation with an expert emergency care provider trained in care of sexual assault/human trafficking. Both cases represent opportunities to improve quality of care provided through knowledge enhancement. Advancing awareness for nurse leaders about human trafficking as a significant health care issue is a primary goal of this quality improvement initiative. Provision of a brief educational program designed to inform nurse leaders about signs and symptoms of human trafficking, at risk populations, impact of human trafficking on victims, providers and society, the use of a screening tool to inform efforts of detection, and available resources that can be offered to victims supports the accomplishment of this primary goal.
**Available Knowledge**

There is no national or international standardized education or screening process established to guide identification and treatment of human trafficking victims. Little is known about the knowledge and confidence levels of providers to screen and treat victims of human trafficking due to a dearth of studies dedicated to discovery of this data (Powell, Dickinson & Stoklosa, 2017). In 2015, a study by Beck et al. identified gaps in general knowledge of human trafficking. Awareness of human trafficking as a healthcare problem was identified as the greatest barrier to victim identification (Beck et al. 2015). Initiatives designed to increase awareness of human trafficking for clinicians have been proven highly successful, even when brief, single session approaches are used. In a study by Beck et al. (2015), training on screening methods for victims of human trafficking had a positive correlation to the ability of providers to correctly answer knowledge questions and a positive correlation to self-reported provider confidence in ability to detect victims in a clinical setting. In a survey, these researchers found that healthcare providers who had even brief education about human trafficking were more likely to view human trafficking as a significant issue in healthcare and demonstrated higher knowledge and confidence in detection scores than providers without training (p<0.001) (Beck et al., 2015).

Grace et al. (2014) studied 20 large medical centers in the San Francisco Bay area and found that brief training (20 minutes) on screening methods increased provider knowledge and self-reported provider confidence in ability to detect victims. Participants in the intervention group reported greater increases in their level of knowledge about human trafficking versus those in the delayed intervention comparison group (1.42 vs −0.15; adjusted difference = 1.57 [95% confidence interval, 1.02–2.12]; P < 0.001). Pretest ratings of the importance of knowledge about human...
trafficking to the participant's profession were high in both groups and there was no intervention effect (0.31 vs 0.55; −0.24 [−0.90–0.42], \( P = 0.49 \)). Knowledge of how to access appropriate resources for identified victims of human trafficking increased from 7.2% to 59% in the intervention group and was without change (15%) in the delayed intervention comparison group (61.4% [28.5%–94.4%]; \( P < 0.01 \)). Participants who suspected their patient was a victim of human trafficking increased from 17% to 38% in the intervention group and remained unchanged (10%) in the delayed intervention comparison group (20.9 [8.6%–33.1%]; \( P < 0.01 \)). Both studies (Beck et al., 2015, Grace et al., 2014) identified lack of education and lack of awareness as the greatest barriers to action regarding care of human trafficking victims. A brief educational intervention demonstrated clinical and statistical significance to improve provider knowledge about human trafficking, provider confidence related to ability to detect victims and awareness of human trafficking as a significant healthcare issue.

Powell, Dickinson & Stoklosa (2017) state that there has been little evaluation of the impact of provider training. The authors published a study in 2017 which demonstrated a need for standardization of education and screening practices to identify victims of human trafficking in order to build an evidence base and develop metrics for evaluation of effectiveness of processes. Improving the ability of clinicians to identify and treat victims of human trafficking supports the NAM framework for delivery of high-quality healthcare (Harris, Roussel, Dearman & Thomas, 2016). This population is widely recognized to be under-identified and often inappropriately treated when presenting for healthcare. Even when human trafficking victims are identified, they are often mistreated or untreated as a direct result of lack of treatment strategies informed by evidence-based practice (Beck et al., 2015). Clear recognition by the healthcare system of the need to accurately recognize and treat human trafficking victims, along with a
current increase in political and social awareness of human trafficking as an issue that must be eradicated, support a quality improvement initiative aimed at identification and treatment of human trafficking victims. Many victims of human trafficking are disenfranchised and marginalized, including both legal and illegal immigrants as well as individuals with mental health disorders and substance use disorders (MacDonald, in Scannell, 2018). The economic and social costs of human trafficking are vast (Reed, Roe, Grimshaw and Oliver, 2018). The call for training in the detection and treatment of human trafficking within healthcare, political and legal sectors has contributed to development of a compendium of free and low-cost resources which can be used to create quality improvement initiatives (Powell, Dickins & Stoklosa, 2017).

Despite availability of resources, utility remains limited due to a general lack of awareness of human trafficking as a healthcare issue. Increasing awareness through education is essential to optimizing the health and wellness of human trafficking victims and society in general. Quality improvement initiatives designed to improve detection and treatment of human trafficking victims have demonstrated efficiency in improving provider confidence in the care of victims (Beck et al, 2015, Grace, Lippert & Horwitz, 2014, Powell, Dickins & Stoklosa, 2017).

Development of a quality improvement initiative to provide education about human trafficking that supports screening practices and resource allocation for victims at this organization is necessary to edify the common mission and vision of healthcare organizations to reduce harm and restore wellness.

Rationale

A clinical needs assessment based on the NAM six aims provides a strong justification for implementation of this quality improvement project. Previously provided background information demonstrates that nearly 90% of human trafficking victims are unidentified by
healthcare providers and that there is no existing protocol for education and screening outside of the ED. The NAM aim: Safe has not been met. Brief training has been demonstrated to increase provider knowledge and confidence in screening and care practices. Implementation of training will support the NAM aim: Effective which has not been met. The NAM aim: Efficient and the NAM aim: Timely have not been met as screening does not occur at all in admitted patients. Failure to identify human trafficking victims results in increased morbidity and mortality for this patient population and disparities result when patients do not receive necessary screening for human trafficking. The NAM aim: Patient-Centered and NAM aim: Equitable have not been met (Macias-Konstantopoulos, 2016, Harris, Roussel, Dearman & Thomas, 2016).

Human trafficking can affect any individual, but highly vulnerable populations include documented and undocumented migrants, runaways and marginalized individuals, such as those suffering from substance use disorders, mental health disorders and homelessness (MacDonald, in Scannell, 2018). The site for deployment of this quality improvement initiative was a major urban hub in the Northeast United States. Large numbers of each of the at-risk group/vulnerable populations inhabit the location and receive healthcare at the organization. The organization offers multiple specialty clinics that treat substance use disorder and mental illness, lending to a large catchment of potential human trafficking victims. The organization also has a number of ethnic and gender-based clinics that provide care to special populations deemed at-risk for human trafficking. In addition, the organization includes a large Level 1 Trauma ED with more than 60,000 annual visits and a planned expansion which will increase the volume of a portal through which potential human trafficking victims may be admitted to inpatient settings. The setting has documented intake of human trafficking victims, making a quality improvement initiative which focuses on human trafficking victims appropriate and timely. Nursing
leadership was identified as the most appropriate population for deployment of this quality improvement initiative due to the ability of this group to influence process and policy within the organization (Adams, Djukic, Gregas & Fryer, 2018, Zangerle, 2018). Changes in both process and policy are necessary to effect positive changes in patient, organizational and societal outcomes, which is the terminal intent of the quality improvement initiative.

Kakar (2017) states that there is not a universally recognized framework for understanding human trafficking. Human trafficking is multi-dimensional and contextual based on its form and geographical location of occurrence, which is often trans-national. A multitude of macro-factors including economics, culture, globalization, organized crime, corruption, legal systems, technology, politics, social structures, migratory patterns and labor forces impact how human trafficking is understood. Human trafficking is a condition which often intertwines healthcare, legal, political, social and economic factors resulting in the use of different theoretical paradigms to understand the condition, based on context of methodology or line of inquiry being applied to the subject (Winterdyk, 2019).

For the purpose of this quality improvement project, a victim-oriented framework and theory was used to explain human trafficking. Victimology paradigm involves multiple theories including social learning theory, life course theory, routine activities theory, rational choice theory, neutralization theory, constitutive theory, anomie theory and feminist perspective as integrative to explain human trafficking as a crime of opportunity in which participants do not act volitionally (Winterdyk, 2019). Framework for development/planning of this DNP project was based on the Iowa Model of Evidence-Based Practice (used with permission, University of Iowa Hospitals & Clinics, 2015, Reavy, 2016). (Appendix A).
Current data demonstrates that victims of human trafficking represent a significant part of the population and remain under-identified and therefore subject to inequity of healthcare resources. Victim estimates of between 20 and 40 million are thought to be conservative due to acknowledged deficiencies in ability to detect and identify human trafficking at the global level (Long & Dowdell, 2018, Tracy & Macias-Konstantopoulos, 2018, Leslie, 2018, Macias-Konstantopoulos, 2016). Countless victims remain undiscovered. The need for quality improvement in this area of healthcare is critical and must be addressed. In 2018, TJC issued guidance for healthcare providers on how to identify signs and symptoms of human trafficking, citing that more than 40,000 cases of human trafficking had been reported between 2007 and 2017 by the National Human Trafficking Resource Center (NHTRC) (TJC, 2018b). TJC states that screening for human trafficking is a responsibility of all healthcare providers. Government agency data from the United Nations Palermo Protocol, the United States Victims of Trafficking and Violence Prevention Act of 2000 (TPVA) and the Office on Trafficking in Persons (OTIP) supports that human trafficking is a public health issue affecting individuals, families and communities, with a disproportionate impact on the most vulnerable (TJC, 2018b).

Failure to identify victims of human trafficking is a direct result of gaps in knowledge (Beck et al, 2015). Increasing provider knowledge about signs and symptoms of human trafficking and at-risk populations using evidence-based information is foundational to efforts to improve detection and treatment practices (Scannell, MacDonald, Berger & Boyer, 2018, Powell, Dickins & Stoklosa, 2017). Focus on nursing leaders as key stakeholders in a change process that will address knowledge gaps and deficiencies in care is a highly effective platform to ensure that wide-scale, evidence-based practice change will lead to quality improvement. Nursing leaders have the ability to influence policy and practice at the organizational level and beyond. A multi-
state study conducted by Adams, Djukic, Gregas & Fryer (2018) stated that nurse leaders constitute the largest group of healthcare leaders and hold a powerful position to improve quality by influencing changes in the practice environment. A quality improvement initiative focused on informing nurse leaders about human trafficking as a healthcare concern within the service population provides tools that can be used to disseminate knowledge and resources across organizations and promote evidence-based screening practices will facilitate awareness of human trafficking as an actual or potential healthcare issue for patients.

Victims of human trafficking have been identified by ED staff at the site. ED staff receive training in the care of sexual assault victims that includes a brief component focused on signs and symptoms of human trafficking, as there can be cross-over in the populations. According to Scannell, MacDonald, Berger and Boyer (2018), human trafficking education designed for healthcare professionals must include information on the scope of the problem, signs and symptoms, forensic interviewing techniques, medical treatment pathways guided by principles of trauma-informed care (TIC) including psychological evaluation/treatment, risk assessment and safety planning and resource allocation specific to each victim’s particular needs.

Single session brief education about human trafficking for nursing leaders is a logical and high-impact approach to begin the necessary quality improvement process to educate all clinical staff so that evidence-based practices of screening and detection can be employed across the organization. Healthcare agencies, political agencies, legal agencies and non-governmental organizations endorse the need to increase awareness about human trafficking so that detection, treatment and recovery of victims is possible. Nurse leaders are in a prime position to begin quality work that will culminate in broad based dissemination of evidence-based screening practices for human trafficking within non-emergency settings of healthcare organizations.
Informing nurse leaders about human trafficking as a significant healthcare issue is essential to create foundational support for changes in organizational policy and practice that will lead to improved healthcare outcomes for victims of human trafficking. According to Zangerle (2018), nurse leaders are in a unique position to address the public health issue of human trafficking because of their powerful influence on nursing practice across the healthcare continuum. Nurse leaders can promote the development and implementation of screening and treatment policy and practice within their organizations, ensuring their healthcare teams are prepared to identify human trafficking victims, as well as those at risk for trafficking. Providing a foundation for this quality improvement initiative at the nurse leadership level will create a lexicon to inform the care of human trafficking victims within the organization and beyond. Quality improvement in this area will provide important evidence to inform future clinical practice and surveillance data that can be used to help eradicate human trafficking as a healthcare issue and a societal crisis.

Egyud, Stevens, Swanson-Bierman, DiCuccio and Whiteman (2017) conducted a study in which brief education on human trafficking was followed by a self-informed survey of providers. 75% of participants reported that education improved confidence in ability to detect victims of human trafficking. Furthermore, the authors informed that actual human trafficking victim detection resulted from the initiative. Beck at al. (2015) and Grace et al. (2014) demonstrated similar study results. Results of these studies support that the interventions and strategy for deployment of the quality improvement initiative will be successful.

**Specific Aims**

The specific aims of this quality improvement process included testing the strength of a brief educational intervention focused on nurse leaders to effect buy-in for creation of education and screening practices related to human trafficking. Addressing the current gap in knowledge of
Creating Buy-In Through Education: Human Trafficking

Human trafficking as a healthcare issue was a primary aim. Increasing awareness of human trafficking as a serious threat to both individual and community health was a pivotal aim to facilitate the quality work that is necessary to develop and implement organization-wide education on human trafficking and screening practices. These efforts improve detection of victims and treatment modalities which will support recovery and restoration for victims (Macias-Konstantopulos, 2016, Powell, Dickins & Stoklosa, 2018). This quality improvement project intended to create a foundation for ongoing work that includes implementation of standardized education and screening practices guided by a protocol for care of human trafficking victims. In order to create and sustain support for efforts to ensure broadscale education and screening practices, engagement of nursing leaders as primary stakeholders was essential. Zangerle (2018) describes the high impact that nurse leaders have to create practice change specific to human trafficking awareness and detection strategies. This cannot be understated. Nurse leaders are prime influencers of organizational policy and practice. Buy-in from nurse leaders is critical to creating necessary supports that will influence enhanced clinical practice in the area of screening and detection of human trafficking on a broad level. Providing education to nurse leaders that accurately describes the impact of human trafficking on the healthcare environment along with a well-developed plan to address gaps in knowledge and provide all necessary resources to combat the threat that human trafficking creates for victims, healthcare providers and society is key to promoting buy-in. Knowledge of topic matter, appreciation of impact at a personal/professional level and resource availability create the conditions of psychological meaningfulness, psychological safety and psychological availability that are imperative to creating buy-in for change processes (French-Bravo & Crow, 2015). A robust educational initiative is imperative to provide nurse leaders evidence and data that is
necessary to create support for changes in clinical practices and organizational policy for quality improvement specific to a vulnerable and underserved population and in alignment with NAM quality aims (Macias-Konstantopoulos, 2016, Powell, Dickins & Stoklosa, 2018, Harris, Roussel, Dearman & Thomas, 2016).

Another important aim of this quality improvement initiative was to provide victim advocacy through improved processes of detection and treatment. Opportunities for victims to exit human trafficking situations are typically very limited and extremely high risk for victims (and potentially risky for those assisting victims). Engagement with healthcare providers may be the only situation in which a victim has access to a potential exit route (Scannell, MacDonald, Berger & Boyer, 2018). Awareness of signs and symptoms of human trafficking and screening for human trafficking are critical components to safe exit planning. Cumulative efforts will add to the body of knowledge about care of human trafficking victims for purpose of advocacy. Contribution to the knowledge bank will also inform ongoing development of evidence-based practices that enhance care and advocacy for victims of human trafficking within healthcare settings and beyond (Scannell, MacDonald, Berger & Boyer, 2018). The creation and implementation of a comprehensive education process focused on informing clinical staff about the risks of human trafficking and the importance of screening was the ultimate aim of this quality improvement endeavor. Zangerle (2018) endorses that nurse leaders have an obligation to their organizations and their communities to advocate for policy and practice that supports increasing awareness, providing education and supporting all efforts to detect and treat human trafficking, including screening for risk and collaborating with interdisciplinary providers to ensure that a robust, patient-centered resource base exists to help move victims towards recovery and restoration.
This quality improvement intervention was expected to be successful based on the results of multiple studies that have demonstrated significant improvement in self-reported provider knowledge and confidence levels regarding ability to detect human trafficking victims using similar methodology. There is evidence that actual victim detection results from education and screening practices (Egyud et al., 2017, Stevens, Beck et al., 2015, & Grace et al. 2014). A need for education about human trafficking and screening for human trafficking as a component of inpatient care has been identified by both healthcare and government stakeholders (TJC, 2018b). Zangerle (2018) cites that nurse leaders are high impact agents of change. Educating nurse leaders about human trafficking is a primary strategy to create needed changes in policy and practice. Education is essential to buy-in and buy-in is the first step in creating change. This quality improvement initiative aligned directly with the organization’s mission statement which includes a vision of a healthier world supported by a mission to maintain and restore health through education and high-quality patient-centered compassionate care (www.brighamandwomens.org/about-bwh/vision-and-mission). Development of a common protocol for care is an intended terminal effect of the quality improvement initiative that was beyond the scope of this project.

**Methods**

**Context**

A number of actual and potential cases of human trafficking recently identified in inpatient and non-emergency settings at a large urban medical center in the Northeast United States resulted in recognition of need to develop a standardized education and screening process to improve detection of victims and victim care. At present, the ED is the only area of the organization which offers education and screening for human trafficking. A quality improvement
initiative designed to inform nurse leaders about human trafficking as a healthcare concern was deployed. The aim of the initiative was to create buy-in for implementation of education and screening practices in inpatient and non-emergent settings in the organization. The selected subject group was the Nurse Leadership Council (NLC) of the organization which consists of 191 nurse leaders including unit directors and professional development managers. Convenience sampling was employed. Participation was voluntary. Ethical principles that guide responsible conduct for research (RCR) and quality improvement, respect for persons, beneficence and justice guided methodology (Harris, Roussel, Dearman & Thomas, 2016).

**Intervention**

The specific intervention was a brief educational presentation that included a PowerPoint presentation defining human trafficking and its prevalence and impact on healthcare and society, identification of at-risk populations, signs and symptoms (“red flags”) of human trafficking, a prospective screening tool for use in inpatient settings, and care strategies based on principles of TIC. The participant group was provided with the pre-assessment survey via email 20 days prior to the intervention. Scheduled reminders were sent to those who did not respond every 72 hours to stimulate response rates. The pre-assessment survey closed one hour prior to the delivery of the intervention.

The intervention was delivered in a live presentation before approximately 70 members of the participant group and was also simultaneously available to approximately 10 additional participants via conference call. Participants were provided with written resources based on the PowerPoint presentation to enhance understanding of human trafficking as a healthcare issue. Three vignettes based on actual human trafficking cases detected at the organization were provided to participants to enhance understanding of victimology (Appendices B, C & D). All
documents were provided via email. The intervention was also delivered to the entire participant group as an audio-video presentation with all resources as email attachments at the time of the live presentation. The post-assessment survey was delivered to the participants one hour after the delivery of the intervention. The post-assessment survey was available to the participants for 20 days and email reminders were sent to participants who did not respond every 72 hours until the survey closed. Effects of the intervention were measured using a REDCap tool to assess and compare pre and post levels of provider knowledge about human trafficking and confidence in victim identification/care. Each survey was de-identified to ensure confidentiality for participants. Measurement of pre and post participant support for organization-wide education and screening for human trafficking were assessed. A goal of endorsement of support for organizational wide education and screening for human trafficking was established. Achievement of this goal supported a possible future web-based education program integrated into an existing organization web-based education tool along with a screening tool and protocol to guide care that will be embedded into the existing custom-built, modifiable EHR. This phase of the quality improvement project is beyond the scope of this scholarly project. This scholarly project was foundational to full implementation of a broad-based quality improvement initiative at the organization.

The team included a faculty and organizational mentor as well as the DNP candidate. The DNP candidate developed all interventions with consultation from other team members. The quality improvement intervention was presented by the DNP candidate and all data collection and data analysis was performed by the DNP candidate with appropriate oversight from mentors. Ad hoc team members include subject matter experts in human trafficking who provided
feedback related to screening questions and other matters of expert opinion as well as data analysis experts.

Appendix E contains the REDCap data collection tool. A flow chart to guide providers on how to implement screening for human trafficking is offered in Appendix F. Proposal of a protocol for the care of human trafficking victims is provided in Appendix G. A validated or non-validated screening tool was proposed for use and available internal, local and national victim-centered resources were identified. Appendix H offers a brief screening tool created by this author based on both validated and clinically proven screening tools and was suggested by the author for use at the organization. A number of screening tools were identified and are offered for review in the section Screening Tools.

Participants were provided with resource handouts that can be used to create unit-based repositories to reinforce learning and sourced to support quality improvement through appropriate screening strategies for human trafficking. Data from pre and post assessment were analyzed to determine effectiveness of the intervention within the participant group.

Miller, Chisolm-Straker, Duke and Stoklosa (2019) recommend the following guidelines for educational programs on human trafficking. These guidelines were used to create the intervention:

(1) Require education on HT that provides evidence-based, survivor and trauma-informed training programs delivered by subject matter experts. Powell, Dickins, and Stoklosa (2017) have identified that development of most currently available HCP education has been organic in nature and provides a set of recommendations for quality evidence-based HCP education on HTs (Table I).

(2) Identify the target audience to customize program content.
(3) Identify your primary patient population and highlight cultural influences in the region. For example, the majority population in South Texas is Hispanic/Latino and therefore, programs should be bi-lingual, in English and Spanish, and inclusive of cultural influences and vulnerabilities unique to local Hispanic/Latino populations.

(4) Identify institutional resources, such as funds available for program development and deployment, including employee payroll costs for continued learning time.

(5) Identify the time needed for program delivery and format of content delivery. For example, will the training be a one-hour web-based delivery, a four-hour web-based delivery, an hourlong in-person delivery, a hybrid of web-based and in-person delivery, or entire elective university-based course?

(6) If the organization prefers to develop their own course, after identifying steps 1–5, use the Individual Content Validity Index’s (ICVI) reported in Stoklosa et al. (2019) and Chisolm-Straker et al. (2019) to prioritize curricular content. The ICVIs report the content that subject matter and survivor experts report as most important for inclusion in HCP training on trafficking. When using the ICVI, the development team can maximize training time by focusing on the ICVIs with the highest consensus (closest to 1.0).

(7) Use peer-reviewed, original literature and research as the curricular base. If the organization does not subscribe to literature databases, such as Pub-Med and CINHL, partner with an entity that does. Seek assistance in conducting literature reviews if the team is unfamiliar with searching academic databases and needs assistance with what literature constitutes “peer-reviewed” literature. Free access to a compendium of some of the latest evidence-based literature is available at www.HEAL Trafficking.org.

(8) Once the program draft is complete, request peer-review from subject matter and survivor
experts across disciplines. With their input, revise accordingly.

(9) Assess attendees’ reported change in knowledge levels and obtain feedback post-training; use this information to adjust trainings accordingly,

Table 1

*Toward Evidence-based Health Care Provider Education on Trafficking in Persons:*

Recommendation

Adapted with permission from Powell et al. (2017)

<table>
<thead>
<tr>
<th>Content and Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content should be standardized to provide consistent, correct information regardless of venue, format, audience, and experience levels. The material should be informed and inclusive of survivor voices, victim-centered, culturally relevant, gender sensitive and evidence-based. Finally, when appropriate, content should be delivered utilizing a variety of delivery methods such as simulation, flipped classrooms, and role-playing.</td>
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<table>
<thead>
<tr>
<th>Evaluation and Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>To enhance generalizability, develop evaluation metrics to assess changes in knowledge, attitude, and clinical practice. Further develop metrics to assess patient outcomes. Evaluation metrics will help to build the evidence-base when promising practices are identified.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Oversight</th>
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<tbody>
<tr>
<td>Federal agencies such as the United States Department of Health and Human Services Administration for Children and Families working collaboratively with professional specialty organizations would be well suited, with authoritative oversight and resources to help ensure standardization, which is currently lacking across disciplines and programs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research</th>
</tr>
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<tbody>
<tr>
<td>Research and identify the best means to incentivize HCPS to train in TIPs.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborate with groups that conduct education on TIP to learn, reflect, share strategies and for a Quality Improvement Collaborative (QIC) toward enhanced research, innovation, advocacy and funding.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use quality data and published research to advocate for funding for research, training and service provision.</td>
</tr>
</tbody>
</table>

(Miller, Chisolm-Straker, Duke & Stocklosa, 2019)
These guidelines recommend tailoring of educational programs to meet the specific needs of the target audience including timeframe, content and the use of a pre and post knowledge assessment tool (Miller, Chisolm-Straker, Duke & Stoklosa, 2019). The planned intervention for nurse leaders operationalized steps 1-5 and steps 7-9. The intervention provided background knowledge about human trafficking as a global and local healthcare issue and highlighted organization-specific cases of human trafficking to personally engage participants as a method to promote buy-in (French-Bravo & Crow, 2015). The intervention educated participants about signs and symptoms of human trafficking (“red flags”), trauma-informed care (TIC) practices and available internal and external victim resources to demonstrate the feasibility of implementation. The intervention was specifically tailored as a brief educational intervention (20 minutes) with the pre and post assessment tool inclusive of questions to determine support for human trafficking education and screening as an organizational goal to support the highest quality of evidence-based care and inclusivity that are part of the organizational mission (www.https://www.brighamandwomens.org/about-bwh/vision-and-mission).

Nurse leaders are essential stakeholders to create buy-in for this innovative approach to caring for a highly vulnerable population (Zangerle, 2018). It is important to provide nurse leaders with the educational and informational background necessary to inform and change organizational policy and practice so that care is fully aligned with NAM initiatives (Harris, Roussel, Dearman & Thomas, 2016, Zangerle, 2018). This methodology has proven success and was selected based on supportive statistical and clinical evidence (Beck et al, 2015, Grace, et al, 2014, Miller, Chisolm-Straker, Duke and Stoklosa, 2019). When buy-in has been established, the next phase of the quality improvement project will begin the work of creating and implementing a web-based educational program to educate healthcare providers and others about human
trafficking to support the eventual integration of an EHR-based screening tool for use by healthcare providers across the organization. This phase of the quality improvement project was not within the scope of this scholarly project. This scholarly project served as a foundational endeavor to support advancement of nursing practice in the care of human trafficking victims.

**Study of the Intervention**

The intervention was studied by analyzing the results of REDCap data to determine differences in pre and post intervention responses. The intervention was a single session with pre and post assessments completed before and after the intervention. All data collected via REDCap was reviewed for completeness and accuracy. Statistical analysis of data using Excel© was performed to determine if the intervention was responsible for any changes in knowledge levels and provider levels of confidence/support. Results were confirmed by an ad hoc member of the DNP team using Stata©. Due to significant differences in response sample sizes between the pre and post intervention responses along and unpaired responses, data was analyzed using two different methods. The initial analysis involved de-identification of raw data. For each of the demographic questions, percentiles were determined. For each of the knowledge and attitude questions, a mean (M) was determined, confidence intervals (CIs), sample variances (Vs) and standard deviations (SDs) were calculated and an unpaired student two tailed t-test assuming unequal variances was performed. Because the differences in sample sizes were assumed to affect the validity of the results, the data was reanalyzed using a randomization method with random equal sample sizes created. Randomization was performed using the randomization function in Excel©. Sample size was determined by the author based on the greatest number of responses that was included in each sample. The number 50 was the greatest number of responses common to each sample and was used as the standard sample size for each response
group. The data was then analyzed using Excel© with the same statistical calculations performed as for the de-identified raw data. Results for both analyses have been presented.

The null hypothesis was that there would be no statistical difference between pre and post assessments in participant knowledge of human trafficking and participant confidence in ability to detect victims of human trafficking upon completion of the intervention. Rejection of the null hypothesis was an objective of this quality improvement initiative. A desired terminal outcome resultant from the study of the intervention was creation of increased support for implementation of education and screening practices for human trafficking. This was the primary goal of the quality improvement project.

**Measures**

A REDCap tool was created and used to collect data from participants. The questions used in the tool were validated (Katsanis et al., 2019). The REDCap tool included six demographic questions and eight knowledge/attitude questions (Appendix B). Pre intervention data was compared to post intervention data to determine changes in participant knowledge about human trafficking and participant confidence in ability to detect victims of human trafficking. The tool was also used to assess changes in attitudes towards support for organization-wide education about human trafficking and implementation of broad-based screening. REDCap (Research Electronic Data Capture) is a secure web application for building and managing online surveys. It was available at no cost through the organization, was fully customizable and allowed smooth data downloads to common statistical software packages as well as Excel. ([www.projectredcap.org](http://www.projectredcap.org)). This tool was selected due to ease of use, availability and familiarity within the organization and data security. REDCap provided a secure portal that promotes accuracy and completeness of data.
Measures of demographic data were performed in REDCap and captured as percentiles. Demographic data was presented separately for pre and post assessment respondents for purpose of comparison of difference in the populations. Statistical analysis of data was performed using Excel©. For purpose of clear and accurate representation of results, data from the knowledge and attitude questions was analyzed using two separate methods. Results of each data analysis method were presented and described for purposes of comparison and enhanced understanding of impact of the quality improvement initiative.

**Analysis**

Quantitative analysis of results of demographic and pre and post knowledge/provider confidence assessment REDCap tools was performed. Data was reviewed for accuracy and completeness. Microsoft Excel© was used for statistical data analysis. Demographic data was collected and analyzed using REDCap (Tables Ia-VIa, Tables Ib-VIb, TableVII). Comparison of demographic differences in the pre and post assessment respondents was conducted and presented as percentiles. Statistical analysis and comparison between pre and post knowledge/confidence assessments was conducted to detect any changes in levels of provider knowledge and provider confidence. Each question of the tool was categorized independently for improved clarity of effects of intervention. Comparison of pre and post assessment attitudes of support for implementation of education and screening practices related to human trafficking was assessed. Data was presented in a statistical format to demonstrate changes based on implementation of the quality improvement initiative. Statistical analysis of data was performed using two different methods of analysis to determine any impact that differences in the sample sizes between the pre and post assessment surveys might have on results. Results of both analyses were presented for discussion.
**Ethical Considerations**

According to English (2017), increased public awareness of human trafficking has resulted in two major developments that impact victims and healthcare providers in ways that can be conflicted. There is a demand for a response to human trafficking as well as concern that discovery of human trafficking should be designated a reportable condition. Responses to human trafficking often combine medical, public health, social and legal lenses. In addition, many states require mandatory reporting of confirmed/suspected human trafficking by healthcare professionals. The intention of healthcare agents, public health agents and legal agents is to protect victims of human trafficking, but the consequences of reporting often increase risk for victims, including lethal risk. Consideration of available victim-centered TIC resources as well as acceptance of victims for these resources must guide provider approaches to screening for human trafficking. Absence of an appropriate resource base for referral and/or unwillingness of victims to accept services create a moral and ethical hazard for providers as well as victims. Ethical dilemmas that often face providers involve complex situations such as autonomy and patient confidentiality. Personal choices and rights of individuals to engage in activities must be respected by providers. Human trafficking victims may not identify their situation as one of risk, abuse or coercion (English, 2017). Providers may experience ethical and moral distress as a result of feeling unable to protect a victim. Real or perceived knowledge that a victim has left treatment and been further victimized or even killed can lead to devastating personal distress for providers (Association of Women’s Health, Obstetric and Neonatal Nurses [AWHONN], 2016). Similarly, aggressive attempts by healthcare providers to encourage human trafficking victims to either disclose or accept resources can result in moral and ethical distress for victims, who may not be psychologically ready to fully accept offers of help. A guiding concept for healthcare
providers must be the tenet “Do no harm” (Macias-Konstantopoulos, 2017). Screening processes that are implemented without concurrent development/identification of necessary resources and inclusion of principles of TIC for treatment of human trafficking victims can result in deleterious outcomes for both victims and providers. Occurrence of unintended consequences can result in ethical and moral distress for both groups (English, 2017).

Individuals in the participant group were presumed to have varying attitudes about human trafficking and varying levels of knowledge about human trafficking that may affect individual feelings of ethical and/or moral distress (Macias-Konstantopoulos, 2017). Participation in this quality improvement initiative was voluntary. Any participant who desired to recuse before or after the quality improvement process was initiated was allowed to do so. No members of the participant group identified moral, ethical or personal objection to participation to this author. Anonymity of all participants was be maintained.

DNP project proposal approval from the University of New Hampshire Internal Nursing Department Review Board was obtained prior to implementation of the quality improvement initiative. The organization determined that the project did not involve human research and therefore did not require organizational IRB approval. The project was deemed a quality improvement initiative by the organization and approval was confirmed to launch the project with the designated target group. No ethical conflicts were identified.

Budget/Cost-Benefit Analysis

Stakeholders for this quality improvement initiative included the project leader and project team, nurse leaders, including nurse executives, clinical nurses, physician staff, social workers, inpatients and patients evaluated in non-emergency care settings, organizational
security, local law enforcement agencies and the community. Cost-benefit analysis was performed with consideration of all stakeholders.

This quality improvement initiative was designed as a foundation for a larger quality improvement initiative that includes organization-wide implementation of a standardized protocol and education program on human trafficking with screening for human trafficking. The scope of this initial phase of the quality improvement project was focused on creating buy-in for full implementation through increasing awareness of nurse leaders related to human trafficking as a healthcare problem for the population served by the organization. The proposed budget was focused only on the costs for acquisition of nurse leader buy-in. Identified costs for the quality improvement initiative included costs for office, technical and human resources including salaries. The proposed budget for this initiative was $3000. The estimated cost of implementation of this phase of the quality improvement initiative including was $2200.

Financial quantification of the cost of human trafficking to the healthcare system is challenging due to the covert nature of this crime/healthcare issue. The majority of human trafficking victims remain undiscovered during their experiences with the healthcare system, but the financial impact of their health is significant. The American Hospital Association (AHA) offers a comprehensive cost analysis related to the financial impact of care for victims of violence which includes victims of human trafficking. Pro-active and reactive organizational responses to violence as a healthcare issue were estimated to cost the healthcare system $2.7 billion in 2016. The breakdown of this expenditure is as follows:

- $280 million related to preparedness and prevention to address community violence
- $852 million in unreimbursed medical care for victims of violence
- $1.1 billion in security and training costs to prevent violence within hospitals
• $429 million in medical care, staffing, indemnity, and other costs as a result of violence against hospital employees

(American Hospital Association, 2018)

Analysis of actual healthcare costs for a single victim of human trafficking who was treated but remained unidentified by providers at the organization demonstrated that failure to identify the victim as at risk for human trafficking resulted in the victim re-presenting for a second visit in a single 24-hour period. Despite documentation of “red flags” by both nursing and social work during the first episode of care, the victim was not offered resources and was discharged. The victim re-presented with a different complaint several hours after the initial discharge and was then admitted to the ED Observation Unit for psychiatric observation. Again, there was documentation of “red flags” by several different disciplines but no resources were offered. By the time human trafficking was confirmed, the patient had consumed approximately 36 additional nursing care hours as well as additional hours of care from other healthcare disciplines that might have been averted if the patient was identified during her initial six-hour hospital visit. Failure to identify human trafficking in this case resulted in an additional 1.5 patient days of hospitalization (personal communication, A. Meyer, Sept 28, 2019). The impact of unnecessary patient days and additional hour of nursing care and other resources is financially and clinically significant in the current healthcare environment of high demand for limited resources (Deloitte, 2019). In 2015, a study found that the mean total cost of an observation admission was $8162. Commercial insurance typically reimburses $7201 with financial burden to the patient of $962 (Sabbatini, Wright, Hall & Basu, 2018). The Centers for Medicare and Medicaid (CMS) defines the length of stay for observation status as no more than 24 to 48 hours or not surpassing “two midnights”, meaning that if the patient is admitted prior to midnight on
observation day one, he or she must be discharged or admitted as an inpatient after midnight on observation day two (CMS, 2019). Based on the financial data provided by the study (Sabbatini, Wright, Hall & Basu, 2018), early identification of this victim of human trafficking would have potentially eliminated the second visit to the emergency department and subsequent observation admission, resulting in a mean cost savings of $8162. This case analysis offers compelling clinical and financial significance to support that identification of human trafficking victims can reduce healthcare costs. Greenbaum and Stoklosa (2019) state that victims of human trafficking experience a multitude of healthcare issues, including chronic physical, emotional and psychiatric disorders whose sequelae can become more difficult and more costly to treat as a result of remaining unidentified and untreated. These authors propose that early screening and identification practices are pivotal to decreasing healthcare costs and the social burden that results from failure to identify and treat victims of human trafficking.

The budget for this quality improvement initiative is as follows:

- Project Leader Salary = $0 (partial fulfilment of DNP degree requirements)
- Participants Salary = $20 x 100 = $2000
- Administrative Support Staff Salary = $20 x 5hr = $100
- Paper/Office Supplies = $100
- Redcap Tool Analysis of Data =$0
- Total: $2200

Organizational benefits related to detection of human trafficking include harm reduction for victims and caregivers. Mitigation of physical, emotional and psychological threats to victims and caregivers allows victims to begin the complex path to recovery. Early identification and treatment of human trafficking victims can serve to reduce/eliminate future sequelae that serve to
drive up healthcare costs and negatively impact victims. With estimated costs of nearly $3 billion to the U.S. healthcare system noted, a cost of $2200 to a single healthcare facility is a minimal investment for an opportunity to begin to reduce costs of care related to human trafficking while simultaneously providing opportunity to improve individual human lives as well as the condition of the global community (AHA, 2018, Macias-Konstantopoulos, 2016, Powell, Dickins & Stoklosa, 2018).

**Screening Tools**

In 2014, the VERA Institute for Justice published the first validated screening tool for assessment of risk for human trafficking. The Trafficking Victims Identification Tool (TVIT) can be used with adults and children and encompasses both labor and sex trafficking, which are the most common forms of human trafficking (Appendix I). The tool is available in English and Spanish and can be used with an interpreter for patients speaking other languages (www.vera.org).

In 2018, Dignity Health System, HEAL Trafficking and the Pacific Survivor Center developed the PEARR tool that can be used to screen for all forms of abuse, neglect and violence (Appendix J). Because human trafficking employs multiple forms of oppression, the PEARR tool is an excellent screening tool. This tool offers a trauma informed, guided approach to screening that includes resources for victim assistance. The PEARR tool provides prompts to inform providers how to initiate difficult conversations, how to advance conversations when “red flags” or cues that indicate possible human trafficking are identified and when to end conversations (www.dignityhealth.org).

In January of 2018, United States Administration for Children and Families Office on Trafficking in Persons released the Adult Human Trafficking Screening Tool (AHTST) and
Guide. This tool is designed for use in adult populations and offers a brief, trauma informed series of questions that are inclusive of indicators for both labor and sex trafficking. The language of the tool is basic and non-threatening which provides ease of utility even with for providers with little to no training in care of human trafficking victims. This tool has been selected for inclusion in the quality improvement initiative due to its high compatibility with project aims. The tool is a questionnaire that poses 8 questions designed to uncover force, fraud or coercion being applied to the victim either with or without knowledge by the victim that this is occurring. Although this tool has not been validated at present, it reflects most current research and best practice standards in terms of its approach to screening for human trafficking. The AHTST can be reviewed in Appendix K.

Results

The participant group consisted of 191 nurse leaders. Participation in the intervention was voluntary and completion of each arm (pre and post) of the survey was also voluntary. The intervention and pre and post assessment surveys were distributed to all 191 members of the NLC group via email. Attendance of the live presentation of the intervention was voluntary. Application of volunteer and confidential status to this intervention created a condition of inability to ensure that all members of the participant group completed all phases of the intervention. The pre-assessment survey was completed by 91 members (47.6%) of the participant group. The post-assessment survey was completed by 51 members (26.7%) of the participant group. Approximately 70 members (36.6%) of the participant group viewed the live presentation of the intervention with approximately 10 members (5.2%) of the participant group engaging by conference call during the live presentation (approximations are used due to the fact that some members of the participant group may have left the live presentation prior to
completion and some members participating by conference call may have left the presentation prior to completion. It is unknown if any members of the group viewed the presentation but did not participate in the pre and post survey phases of the intervention.

The majority of pre-assessment survey participants were female (N=89, n=81, 91%) aged 55 years or older (N=89, n=39, 43.8%). 75.6% of the participants identified as white (N=85, n=65) with African American/Black as the second most widely represented participant group (N=85, n=10, 11.6%). Other racial groups and those who preferred not to answer comprised the additional 12.8% of the participant group (N=85, n=10). The preponderance of respondents endorsed having spent more than 30 years as nurses (N=86, n=33, 38.4%) with a majority of 29% (N=86, n=26) endorsing one to five years as a nurse leader. The majority of respondents confirmed tenure at the organization of between one and 5 years (N=88, n=25, 28.4%). Post assessment survey respondents had similar representation for gender with female respondents comprising 91.8% of respondents (N=49, n=45) and age of 55 years or greater (N=51, n=26, 51%). Racial breakdown for post assessment respondents demonstrated consistency with pre assessment respondents for majority of identification as white (N=51, n=42, 80.4%) but demonstrated a difference with Hispanic/Latino replacing African American/Black for second racial majority (N=51, n=4, 4.7%). Post assessment respondents endorsed similar percentiles to pre assessment respondents in terms of years as a nurse greater than 30 (N=52, n=23, 45.1%) and years as a nurse leader between one and five (N=51, n=15, 29.4%). Post assessment respondents also had similar percentiles to pre assessment respondents related to years of tenure at the organization with one to five years of tenure representing the majority of the respondents (N=50, n=14, 28%).
Forty members of the participant group (20.9%) completed the pre-assessment survey but not the post assessment survey. Five members of the participant group (2.6%) completed the post-assessment survey but not the pre-assessment survey. Forty-three members of the participant group (22.5%) completed both the pre and post assessment surveys. Figures 1-6 represent demographic differences. Table II represents total survey participation data.

Figure 1

*Gender*

<table>
<thead>
<tr>
<th>Pre-Survey Data</th>
<th>Post-Survey Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (77.9%)</td>
<td>Male (91.1%)</td>
</tr>
<tr>
<td>Female (81.91%)</td>
<td>Female (91.8%)</td>
</tr>
<tr>
<td>Other (0%)</td>
<td>Other (0%)</td>
</tr>
<tr>
<td>Prefer Not to Answer (1.1%)</td>
<td>Prefer Not to Answer (1.2%)</td>
</tr>
</tbody>
</table>

Figure 2

*Age*

<table>
<thead>
<tr>
<th>Pre-Survey Data</th>
<th>Post-Survey Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-35 yrs (9.09%)</td>
<td>20-35 yrs (9.28%)</td>
</tr>
<tr>
<td>36-45 yrs (25.91%)</td>
<td>36-45 yrs (25.2%)</td>
</tr>
<tr>
<td>46-55 yrs (16.18%)</td>
<td>46-55 yrs (17.6%)</td>
</tr>
<tr>
<td>50 yrs or older (35.43%)</td>
<td>50 yrs or older (35.31%)</td>
</tr>
<tr>
<td>Prefer not to answer (1.1%)</td>
<td>Prefer Not to Answer (1.1%)</td>
</tr>
</tbody>
</table>
Figure 3

*Ethnicity*

![Ethnicity Pre-Survey Data](image1)

![Ethnicity Post-Survey Data](image2)

- **Pre-Survey Data**
  - White: 75.6%
  - Hispanic/Latino: 4.7%
  - Black/African American: 11.6%
  - Native American/Alaskan Indian: 3.2%
  - Asian/Pacific Islander: 0.8%
  - Other: 0.8%
  - Prefer not to answer: 0.8%

- **Post-Survey Data**
  - White: 80.4%
  - Hispanic/Latino: 3.3%
  - Black/African American: 9.8%
  - Native American/Alaskan Indian: 0.8%
  - Asian/Pacific Islander: 0.8%
  - Other: 0.8%
  - Prefer not to answer: 0.8%

Figure 4

*Years as a Nurse*

![Years as a Nurse Pre-Survey Data](image3)

![Years as a Nurse Post-Survey Data](image4)

- **Pre-Survey Data**
  - 5-10 yrs: 38.4%
  - 11-15 yrs: 12.6%
  - 16-20 yrs: 9.3%
  - 21-25 yrs: 9.3%
  - 26-30 yrs: 11.6%
  - 31-35 yrs: 11.6%
  - 40+ yrs: 12.6%

- **Post-Survey Data**
  - 5-10 yrs: 45.1%
  - 11-15 yrs: 7.8%
  - 16-20 yrs: 7.8%
  - 21-25 yrs: 19.6%
  - 26-30 yrs: 19.6%
  - 31-35 yrs: 11.8%
  - 40+ yrs: 11.8%
Figure 5

*Years as a Nurse Leader*

<table>
<thead>
<tr>
<th>Pre-Survey Data</th>
<th>Post-Survey Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 yr (2, 20.7%)</td>
<td>Less than 1 yr (2, 7.3%)</td>
</tr>
<tr>
<td>1-5 yrs (28, 20.7%)</td>
<td>1-5 yrs (10, 20.4%)</td>
</tr>
<tr>
<td>6-10 yrs (18, 20.7%)</td>
<td>6-10 yrs (8, 17.6%)</td>
</tr>
<tr>
<td>11-15 yrs (13, 14.9%)</td>
<td>11-15 yrs (7, 14.3%)</td>
</tr>
<tr>
<td>16-20 yrs (16, 17.2%)</td>
<td>16-20 yrs (6, 12.8%)</td>
</tr>
<tr>
<td>21-25 yrs (5, 5.7%)</td>
<td>21-25 yrs (4, 8.6%)</td>
</tr>
<tr>
<td>26-30 yrs (3, 3.3%)</td>
<td>26-30 yrs (5, 3.9%)</td>
</tr>
<tr>
<td>30+ yrs (4, 4.4%)</td>
<td>30+ yrs (3, 5.9%)</td>
</tr>
</tbody>
</table>

Figure 6

*Years at the Organization*

<table>
<thead>
<tr>
<th>Pre-Survey Data</th>
<th>Post-Survey Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 yr (7, 8.9%)</td>
<td>Less than 1 yr (14, 8.0%)</td>
</tr>
<tr>
<td>1-5 yrs (28, 34.2%)</td>
<td>1-5 yrs (28, 18.7%)</td>
</tr>
<tr>
<td>6-10 yrs (8, 10.2%)</td>
<td>6-10 yrs (3, 8.1%)</td>
</tr>
<tr>
<td>11-15 yrs (13, 14.9%)</td>
<td>11-15 yrs (3, 18.0%)</td>
</tr>
<tr>
<td>16-20 yrs (16, 14.8%)</td>
<td>16-20 yrs (1, 6.0%)</td>
</tr>
<tr>
<td>21-25 yrs (13, 14.8%)</td>
<td>21-25 yrs (3, 18.0%)</td>
</tr>
<tr>
<td>26-30 yrs (3, 3.3%)</td>
<td>26-30 yrs (5, 3.9%)</td>
</tr>
<tr>
<td>30+ yrs (4, 12.2%)</td>
<td>30+ yrs (8, 14.0%)</td>
</tr>
</tbody>
</table>
Table 2

Total Survey Participation

<table>
<thead>
<tr>
<th>Pre-Assessment Survey Completed</th>
<th>Post-Assessment Survey Completed</th>
<th>Pre-Assessment Survey Completed without Completion of Post Assessment Survey</th>
<th>Post-Assessment Survey Completed without Completion of Pre-Assessment Survey</th>
<th>Pre and Post-Assessment Surveys Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>47.6% (91)</td>
<td>26/7% (51)</td>
<td>20.9% (40)</td>
<td>2.6% (5)</td>
<td>22.5% (43)</td>
</tr>
</tbody>
</table>

Statistical analysis of data was performed using Excel©. Results were verified using Stata©. Data analysis was performed using two separate methods to improve data clarity and interpretation of data. Both data analyses processes included the use of de-identified raw data. The initial data analysis process involved conventional analysis of group means (M), confidence intervals (CIs), standard deviations (SDs) and variances (Vs) with comparison of unpaired data sets using a student’s two-tailed t-test for unpaired data assuming unequal variances. The second data analysis process involved randomizing all de-identified data and creating samples of equal sizes to determine impact of difference in sample size on data results.

The results for the primary analysis of the raw de-identified data for each of the eight knowledge and attitude questions indicated statistical significance for Question 1, Question 2, Question 3 and Question 6 of the survey; 

**Q1:** I am able to define human trafficking (M=4.078, SD=0.788, 95%CI=3.858-4.297, p=0.016).

**Q2:** Human trafficking is a significant healthcare issues (M=4.509, SD=0.537, 95%CI=4.360-4.659, p=0.001).

**Q3:** Human trafficking affects patients cared for at this organization (M=4.215, SD=0.799, 95%CI=3.993-4.438, p=0.013).
Q6: A 20-minute educational initiative increases knowledge about human trafficking (M=4.117, SD=0.855, 95%CI=3.879-4.355, p=0.021).

Near statistical significance was found for Question 7 and Question 8: Q7: I endorse organization-wide education about human trafficking (M=4.48, SD=0.699, 95%CI=4.283-4.676, p=0.063). Q8: I endorse organization-wide screening for human trafficking (M=4.352, SD=0.770, 95%CI=4.136-4.569, p=0.098).

Question 4 and Question 5 demonstrated no statistical significance in terms of demonstrating that the intervention was responsible for change in participant knowledge levels: Q4: I can recognize signs and symptoms of human trafficking (M=3.7, SD=0.781, 95%CI=3.480-3.919, p=4.417). Q5: I can identify internal and external resources for victims of human trafficking (M=3.588, SD=0.911, 95%CI=3.334-3.841, p=2.36).

Table 3

Two-tailed student's t-test, unpaired assuming unequal variances (red=statistical significance)

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre-M</th>
<th>Post-M</th>
<th>Pre-SD</th>
<th>Post-SD</th>
<th>Pre- 95%CI</th>
<th>Post- 95%CI</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>3.764</td>
<td>4.078</td>
<td>0.653</td>
<td>0.788</td>
<td>3.627-3.900</td>
<td>3.858-4.297</td>
<td>0.016</td>
</tr>
<tr>
<td>Q2</td>
<td>4.191</td>
<td>4.509</td>
<td>0.633</td>
<td>0.537</td>
<td>4.058-4.323</td>
<td>4.360-4.659</td>
<td>0.001</td>
</tr>
<tr>
<td>Q3</td>
<td>3.865</td>
<td>4.215</td>
<td>0.809</td>
<td>0.799</td>
<td>3.695-4.034</td>
<td>3.993-4.438</td>
<td>0.013</td>
</tr>
<tr>
<td>Q4</td>
<td>2.920</td>
<td>3.7</td>
<td>0.757</td>
<td>0.781</td>
<td>2.760-3.079</td>
<td>3.480-3.919</td>
<td>4.417</td>
</tr>
<tr>
<td>Q5</td>
<td>2.730</td>
<td>3.588</td>
<td>0.844</td>
<td>0.911</td>
<td>2.553-2.907</td>
<td>3.334-3.841</td>
<td>2.36</td>
</tr>
<tr>
<td>Q6</td>
<td>3.781</td>
<td>4.117</td>
<td>0.764</td>
<td>0.855</td>
<td>3.619-3.943</td>
<td>3.879-4.355</td>
<td>0.021</td>
</tr>
<tr>
<td>Q7</td>
<td>4.25</td>
<td>4.48</td>
<td>0.694</td>
<td>0.699</td>
<td>4.103-4.396</td>
<td>4.283-4.676</td>
<td>0.063</td>
</tr>
<tr>
<td>Q8</td>
<td>4.123</td>
<td>4.352</td>
<td>0.804</td>
<td>0.770</td>
<td>3.955-4.292</td>
<td>4.136-4.569</td>
<td>0.098</td>
</tr>
</tbody>
</table>

Results for the secondary analysis of the de-identified, randomized and equalized data sample demonstrated very different results. None of the knowledge and attitude questions demonstrated statistical significance. Question 3, Question 5 and Question 6 were closest to
achieving statistical significance but failed to do so: **Q3**: Human trafficking affects patients cared for at this organization (M=0.462, SD=0.296, 95%CI=0.378-0.546, p=0.182) **Q5**: I can identify internal and external resources for victims of human trafficking (M=0.474, SD=0.300, 0.95%CI=0.389-0.560, p=0.230). **Q6**: A 20-minute educational initiative increases knowledge about human trafficking (M=0.539, SD=0.289, 95%CI=0.456-0.621, p=0.22). Question 2 and Question 4 demonstrated p values farthest from the alpha of 0.05. **Q2**: Human trafficking is a significant healthcare issues (M=0.459, SD=0.294, 95%CI=0.412-0.579, p=0.828). **Q4**: I can recognize signs and symptoms of human trafficking (M=0.512, SD=0.273, 95%CI=0.434-0.589, p=0.955). Question 1, Question 7 and Question 8 also failed to demonstrate statistical significance: **Q1**: I am able to define human trafficking (M=0.468, SD 0.304, 95%CI=0.382-0.555, p=0.772) **Q7**: I endorse organization-wide education about human trafficking (M=0.501, SD=0.288, 95%CI=0.419-0.583, p=0.631). **Q8**: I endorse organization-wide screening for human trafficking (M=0.460, SD=0.290, 95%CI=0.377-0.542, p=0.550).

Table 4

Randomized, equal sample size using two-tailed student’s t-test (red=statistical significance)

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre-M</th>
<th>Post-M</th>
<th>Pre-SD</th>
<th>Post-SD</th>
<th>Pre- 95%CI</th>
<th>Post- 95%CI</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>0.486</td>
<td>0.468</td>
<td>0.317</td>
<td>0.304</td>
<td>0.396-0.576</td>
<td>0.382-0.555</td>
<td>0.772</td>
</tr>
<tr>
<td>Q2</td>
<td>0.509</td>
<td>0.495</td>
<td>0.330</td>
<td>0.294</td>
<td>0.415-0.603</td>
<td>0.412-0.579</td>
<td>0.828</td>
</tr>
<tr>
<td>Q3</td>
<td>0.541</td>
<td>0.462</td>
<td>0.294</td>
<td>0.296</td>
<td>0.458-0.625</td>
<td>0.378-0.546</td>
<td>0.182</td>
</tr>
<tr>
<td>Q4</td>
<td>0.508</td>
<td>0.512</td>
<td>0.295</td>
<td>0.273</td>
<td>0.425-0.592</td>
<td>0.434-0.589</td>
<td>0.955</td>
</tr>
<tr>
<td>Q5</td>
<td>0.547</td>
<td>0.474</td>
<td>0.298</td>
<td>0.300</td>
<td>0.462-0.631</td>
<td>0.389-0.560</td>
<td>0.230</td>
</tr>
<tr>
<td>Q6</td>
<td>0.468</td>
<td>0.539</td>
<td>0.294</td>
<td>0.289</td>
<td>0.384-0.552</td>
<td>0.456-0.621</td>
<td>0.22</td>
</tr>
<tr>
<td>Q7</td>
<td>0.530</td>
<td>0.501</td>
<td>0.307</td>
<td>0.288</td>
<td>0.443-0.617</td>
<td>0.419-0.583</td>
<td>0.631</td>
</tr>
<tr>
<td>Q8</td>
<td>0.424</td>
<td>0.460</td>
<td>0.298</td>
<td>0.290</td>
<td>0.340-0.509</td>
<td>0.377-0.542</td>
<td>0.550</td>
</tr>
</tbody>
</table>
Discussion

Summary

This quality improvement initiative was designed to be a foundational component to inform nurse leaders of the need to support standardized education and screening for human trafficking in all inpatient and non-emergency care areas at a large academic tertiary care medical center. The initiative had five primary aims:

- Creation of buy-in for standardized education and screening process including a protocol to guide care for human trafficking victims
- Bridging the knowledge gap related to human trafficking identification and treatment
- Elevation of awareness of human trafficking as a healthcare issue and threat to personal and societal wellness
- Creation of victim advocacy through improved detection and treatment processes
- Development of a foundation for future quality improvement related to care of human trafficking victims

Nurse leaders were engaged as primary stakeholders capable of moving agendas forward to meet all identified aims. Primary data analysis demonstrated that the quality improvement intervention successfully met the aim of bridging the knowledge gap related to human trafficking identification and treatment and the aim of elevating awareness of human trafficking as a healthcare issue and threat to personal and societal wellness. There was also evidence of positive movement towards meeting the aim of creation for buy-in for standardized education and screening process including protocol to guide care for human trafficking victims and the aim of development of a foundation for future quality improvement related to care of human trafficking.
victims. These two aims were the true goal of the quality improvement process. Representation of near statistical significance correlated with verbal and email feedback that endorsed strong support for standardized education and screening for human trafficking including a protocol to guide care. A combination of data with both formal and informal support of the participant group provided evidence of nurse leader group endorsement for the quality improvement initiative and for planned future quality improvement efforts related to care of human trafficking victims at the organization.

Both an unpaired student’s t-test assuming unequal variances and randomized raw data using equal sample sizes are appropriate methods to analyze this type of data. Unpaired student’s t-test assuming unequal variances is a the most powerful statistical method for comparing data sets of unequal size even when sample size is greater than 30 items (Derrick, Russ, Toher & White, 2017). Based on this statement by Derrick, Russ, Toher & White (2017), it is reasonable to adopt a position that the quality improvement intervention was successful.

Secondary data analysis informed that two of the primary objectives for the quality improvement initiative were notable for greatest deviation from statistical significance: Q7: I endorse organization-wide education about human trafficking (M=0.501, SD=0.288, 95%CI=0.419-0.583, p=0.631). Q8: I endorse organization-wide screening for human trafficking (M=0.460, SD=0.290, 95%CI=0.377-0.542, p=0.550). Secondary data analysis did not yield any statistical significance of the quality improvement initiative to meet identified aims. Interpretation of this data should be done with caution as the data analysis method may have introduced unintended bias (Bornstein, Jager & Putnick, 2013). Demographic data for the respondents indicated a high level of homogeneity. The majority of the respondents were white females aged 55 years or older with 30-plus years of nursing experience, one to five years of
nurse leader experience, and one to five years tenure at the organization. Despite the use of probability sampling as an attempt to improve the accuracy of the data analysis process, there is a chance that the high homogeneity of the raw data resulted in a non-probability sample. Homogenous samples often produce data that is not generalizable and should be interpreted with full understanding of the possible effects on probabilities and variations of the data (Bornstein, Jager & Putnick, 2013). Randomized equalized sample sizing was not deemed appropriate as a statistical analysis method for this data set due to risk of introduction of bias. Primary data analysis demonstrated statistical changes and near statistical in knowledge about human trafficking as a healthcare concern and support for screening and education with a protocol to guide care of victims. No statistical change was determined for knowledge questions related to ability to identify victims of human trafficking or to identify treatment resources.

The results of the intervention indicated that the participant group may have possessed some basic knowledge about human trafficking as a healthcare issue. Recent media attention to human trafficking at the national and local level may have helped to provide increased information and awareness to the participant group. In addition, some members of the participant group have been exposed to formal education on human trafficking provided at Nursing Grand Rounds sessions within the past two years. A small number of the participant group have higher levels of knowledge related to human trafficking as a result of work environment and/or nursing specialty focus. These factors could account for the lack of statistical change that was demonstrated by the secondary data analysis method (de-identified randomized data using equal sample sizes).

The respondents in the nurse leader group supported the primary aims of the quality improvement initiative. Opportunity for additional education related to detection and treatment
were evident at the conclusion of the data analysis process. Informally, the participant group endorsed overwhelming support for the quality improvement initiative verbally and via email response after completion of the intervention. The results of the data analysis concur with highly positive feedback and support for future efforts from members of the participant group.

Endorsement of the nurse leader group for the quality improvement initiative was gained both statistically and actively. Executive nurse leadership acknowledged the importance of creating standardized education and screening for human trafficking with a protocol to guide care as an organizational goal. Support for future endeavors was attained. Although the primary goals of buy-in for organization-wide education and screening achieved only near statistical significance, the participant group offered overwhelming support for the quality improvement initiative and future quality goals related to the care of human trafficking victims at the organization.

Limitations

There were several limitations that may have affected the process and outcomes of this quality improvement initiative. The initiative was launched in late fall/early winter of 2019/2020 (11/26/2019-1/6/2020) during a period of time that included three major holiday/vacation periods. Survey distribution method was via organizational email and delivered reminders to all participants every 72 hours until the survey was completed by the participant or the survey closed. Pre and post survey periods had a notable number of non-respondents identified through automated out of office email responses to the initial survey as well as reminder emails. Launch of the quality improvement initiative during an extended holiday period when many individuals may have scheduled vacation/out of office time may have contributed to low response rates.
Another limitation was the extreme homogeneity of the participant group. Similarities between respondents may have resulted in bias and may make the results of surveys less generalizable.

Inability to perform paired data analysis due to the voluntary nature of each arm of the survey process limited the ability to detect distinct differences in changes of knowledge and/or attitude for individual participants. Ability to perform paired testing of data could offer insight into the effects of homogeneity and demographic influences on the results.

A significant difference in response rates between the pre and post assessment surveys may have affected the statistical findings despite efforts to adjust for these differences using two methods of statistical analysis. The use of a two-tailed student’s t-test assuming unequal variances is a widely accepted and high-power method of statistical analysis for the determination of differences between the means of two samples of unequal size (Derrick, Russ, Toher & White, 2017). According to Bornstein, Jager & Putnick (2013), the use of randomization methods and creation of equal sample sizes in highly homogeneous data sets may produce results in which unintended bias has been introduced. Differences in the two sets of statistical results affect the level of confidence with which these results can be interpreted.

Conclusions

Human trafficking is a global healthcare crisis. Standardized education, standardized screening practices and a standardized protocol to guide care of victims must be developed in order to combat this crisis effectively. The addition of formal education and standardized screening practices with a protocol to guide care in the ED at the organization resulted in discovery of several human trafficking victims. Many of these victims were able to move towards wellness as a result of detection and direction to resources. Continued work to develop
standardized processes across the organization must occur in order to ensure that all victims of human trafficking have access to care that is essential to both health and freedom.

The data presented reflects that the quality improvement initiative influenced movement towards meeting the aims of creation of buy-in for standardized education and screening process including a protocol to guide care for human trafficking victims, creation of victim advocacy through improved detection/treatment processes and development of a foundation for future quality improvement related to care of human trafficking victims. Nurse leaders are a powerful force for change. A shared governance structure provides nurse leaders a strong platform to introduce evidence-based practice and policy changes. Endorsement of support from the nurse leader group established a foundation for continued efforts to fully implement standardized processes to enhance detection and treatment of human trafficking across the organization. Education of nurse leaders about human trafficking as a healthcare issue, including how to screen, identify and treat victims, is paramount to improving the quality of life for victims and improving the condition for society in general (Egyud et al., 2017, Stevens, Beck et al., 2015, & Grace et al. 2014). Nurse leaders have the ability to influence policy and evidence-based practice to create tangible changes for both consumers and providers of healthcare (Zangerle, 2018). Buy-in for an action plan must be developed at the level of nurse leaders. Policy and standards, processes and outcomes that are robust and capable of effecting positive broad scale and wide scope changes will result from engagement of nurse leaders.

Primary data analysis offers statistical evidence that all aims of the quality improvement initiative were satisfied. This quality improvement initiative helped to identify areas for future efforts in the arenas of policy, education and clinical practice related to the care of human trafficking victims at a large urban academic trauma center. Broad opportunities exist to engage
nurse leaders as stakeholders and primary advocates for creating evidence-based changes that will improve the lives of victims of human trafficking who engage with the healthcare system. Future efforts should focus on continued engagement of nurse leaders to create policy that standardizes education and screening practices related to human trafficking and defines a standardized protocol to guide care. Efforts should also be disseminated to include clinical nurses and other professional disciplines (physician, social work, internal and external advocacy groups) as partners in a multi-disciplinary, intra-professional collaborative for advancing knowledge to inform the care of human trafficking victims.

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References


two samples that include both paired and independent observations. *Journal of Modern Applied Statistical Methods, 16*(1), 137-157. doi: 10.22237/jmasm/1493597280


Macias-Konstantopoulos, W. L. (2016). Human trafficking: The role of medicine in interrupting the cycle of abuse and violence. *Annals of Internal Medicine, 165*(8), 582-588. doi:10.7326/M16-0094


Organization of Nurse Executives, September, 2018, 16-19.

Appendix B

Clinical Vignette #1- Kourtney

Kourtney is a 21-year-old Caucasian female college student. She meets an older man while out at a bar. They begin a romantic relationship. Kourtney’s new boyfriend begins to isolate her from her friends and family. She drops out of college and moves in with him. Eventually, she refuses to contact her family. Her mother is panicked and alerts the police. Kourtney and her boyfriend are evasive and avoid being discovered for several months.

Kourtney’s mother receives information from an individual who tells her that Kourtney has been seen at a motel in a neighboring city. Kourtney’s mother informs the police who go to the location and find Kourtney is a motel room with a man. Kourtney seems impaired and there is evidence of needle marks on both of her arms. Kourtney is taken to the emergency department where her mother meets her.

Kourtney is noted to be under the influence of substance and has significant physical trauma consistent with physical and sexual abuse. When Kourtney is medically stabilized, she is asked by an RN trained in screening and care of victims of human trafficking in a trauma-informed manner about her circumstances. Kourtney tells the RN that her boyfriend had become physically abusive and refused to allow her to contact family and friends. When he realized that Kourtney’s mother was trying to get her to come home, he moved them from place to place. He forced Kourtney to have sex with men and women for money. When Kourtney tried to resist, he began to inject her with heroin and to give her other drugs and alcohol to gain control. Kourtney tells the RN that she believes she has been forced to have sex with as many as 40,000 individuals. Kourtney was discharged from the ED with resources and continues to recover.
Appendix C

Clinical Vignette #2- Kim

Kim is a 28-year-old African American woman. She is an insulin dependent diabetic. She is a licensed plumber. She is a single mother with two children under the age of 10. Kim took a job with a large plumbing company in the Boston area. After a short period of time, she becomes romantically involved with the owner of the company. The relationship seems perfect. Kim’s new boyfriend offers to allow Kim and her kids to live in a home that he owns. Her boyfriend treats her well initially. Eventually, Kim’s boyfriend begins to ask her to do things that make her feel uncomfortable. He asks her to perform sex acts that she does not want. Her boyfriend pressures her to comply, reminding her of all he has done for her. He tells her how lucky she is to have a successful businessman taking care of her and her kids. He assures her that no man will take on the burden of a single mother with two kids. He tells her there are other women who will gladly do what he asks in exchange for being taken care of so well. Kim feels she had no choice but to do what was asks of her. She feels obligated to her children to see that their lives are not disrupted. Kim does what he asks but feels ashamed.

Over time, Kim’s boyfriend begins to suggest other activities that Kim does not feel comfortable with. These activities involve Kim “contributing” economically. Kim no longer works as a plumber in her boyfriend’s company. He wants her to be available to him at all times. Kim’s boyfriend tells her if she loves him and wants to continue to live with her kids in the manner she is used to, she needs to do what is asked. Kim’s boyfriend posts an online ad offering group sex with Kim as a participant. Kim is forced to participate in several group sex encounters arranged by her boyfriend. He occasionally participates as well. Kim is given alcohol and perhaps drugs by her boyfriend to “help her relax” during these encounters. Kim’s memories are vague and often terrifying. She remembers being restrained and violently sexually assaulted at times. She feels powerless to stop this activity as she fears for the safety of her children and herself if she attempts to escape.

After a several days of being sexually trafficked by her boyfriend, Kim’s blood sugar becomes extremely high. She has been given a large amount of alcohol and perhaps drugs and can’t remember if she took her insulin. She becomes very ill and unable to participate in the encounters. Her boyfriend allows her to take an ambulance to the emergency department but does not accompany her. In the ED, Kim is treated for diabetic ketoacidosis. She does not reveal any information about being forced to have sex for money and shelter. Kim remains in the ED for 2 days awaiting an inpatient bed. She is cared for by many nurses and doctors during that time. She tells no one about situation. Just prior to being transferred out of the ED to an inpatient bed, Kim is cared for by an RN who has been trained in the care of victims of human trafficking. The RN asks Kim about her occupation and her living situation. The RN notices that Kim seems a bit hesitant to answer. The RN respects Kim’s decision to protect her privacy but changes the approach by asking Kim what it is like to work as a plumber, a trade that is primarily male. She is asked if there was ever a time that she was asked to do something that she did not want to do or felt uncomfortable doing as part of her job. Kim begins to share information about the plumbing industry and eventually reveals her human trafficking story to the RN. Kim is offered resources which she accepts. A “warm handoff” to existing organizational services is performed. Kim is able to exit her human trafficking situation safely and at her own pace. Kim is currently working as a plumber and is caring for her children.
Appendix D

Clinical Vignette #3- Khloe

Khloe is a 19-year-old African American woman. She arrives to the emergency department in an ambulance after a minor motor vehicle crash. Her boyfriend was driving the car and arrives with her. They have no visible injuries, but Khloe has an ultrasound picture that she is desperately showing to the EMTs and the triage RN. Khloe tells them that she is 8 weeks pregnant and is very worried about her baby. She is afraid that her baby has been hurt. She pleads for the staff to take care of her baby.

Khloe and her boyfriend are taken to separate rooms for evaluation. As part of her evaluation, a pelvic ultrasound is performed to check the status of the fetus. Khloe’s ultrasound does not show an existing pregnancy and her exam is not consistent with a recent miscarriage. Khloe is informed that she is not pregnant. She is visibly shaken. Staff attribute this to both the accident and the loss of a pregnancy she believed was present, but do not explore the inconsistencies with her reported pregnancy and her clinical exam. Both Khloe and her boyfriend are eventually discharged from the ED.

A few hours after Khloe is released, she returns alone to the ED triage area. She tells the RN that she feels depressed and suicidal related to the loss of her pregnancy. She is admitted to the ED Observation Unit with a Section 12 order for protection and a plan to admit to an external clinical stabilization unit (CSU) for further care. During her stay in the ED Observation Unit, Khloe has many phone calls from her boyfriend, and he visits for long periods of time. She is noted to be quiet and cooperative by the staff. Staff notice that Khloe has a large tattoo on her chest of a man’s name. The tattoo looks relatively new. When Khloe is asked about the meaning of the tattoo by several staff members, she seems embarrassed and cannot answer the questions.

Khloe is approved for a CSU bed after about 36 hours in the ED Observation Unit and arrangements are made for her to transfer via ambulance. Just prior to the arrival of the ambulance, an RN trained in the detection and screening of human trafficking overhears two staff members discussing Khloe and her tattoo. The RN recognizes that Khloe may be a victim of human trafficking and asks if she can speak with Khloe. Khloe agrees to speak with the RN. Knowing that there is limited time, the RN informs Khloe that she is concerned that Khloe may be in a dangerous situation and tells Khloe that she is concerned for her safety and can provide immediate resources for Khloe if she needs to exit a dangerous situation. The RN asks Khloe if anyone is making her do anything that she does not want to do. Khloe tells the RN that her boyfriend has been making her have sex for money. She also tells the RN that she was recently evicted from an apartment that she was paying for with money earned working at a coffee shop because her boyfriend was caught selling drugs from the apartment. She lost her job at the coffee shop because she missed several days of work due to being sexually trafficked and unable to go to her job. Khloe’s boyfriend also forced her to get a tattoo on her chest of his name to “prove” that she was his woman. When the RN asked Khloe why she had not told the many nurses, doctors, social workers and others who had cared for her during her two visits to the ED what was happening to her, she stated, “No one asked me like you did”. Khloe agrees to accept resources and an attempt at a warm handoff was made but could not be coordinated. A plan was made between staff of the ED and staff at the CSU to collaborate to provide Khloe with needed resources the following day. Khloe is transported to the CSU. When she arrives at the CSU, her trafficker meets her on the street. She gets into a vehicle with him and is not heard from again.
Appendix E

REDCap Tool Questions

Demographic Questions

Gender: Male     Female     Prefer Not to Answer

Age: 25-35 years  36-40 years  41-45 years  46-50 years  51-55 years  55 years or older  Prefer not to answer

Ethnicity: White     Hispanic/ Latino     Black /African American     Native American/American Indian     Asian/ Pacific Islander     Other
Prefer not to answer

Years as a Nurse: 5-10 years  11-15 years  16-20 years  21-25 years  26-30 years  Greater than 30 years

Years as a Nurse Leader: Less than 1 year  1-5 years  6-10 years  11-15 years
16-20 years  21-25 years  25-30 years  Greater than 30 years

Years at the Organization: Less than 1 year  1-5 years  6-10 years  11-15 years
16-20 years  21-25 years  25-30 years  Greater than 30 years

Survey Questions

I am able to define human trafficking
Strongly Disagree   Disagree   Unsure   Agree   Strongly Agree

Human trafficking is a significant healthcare issue
Strongly Disagree   Disagree   Unsure   Agree   Strongly Agree

Human trafficking affects patients cared for at this organization
Strongly Disagree   Disagree   Unsure   Agree   Strongly Agree

I can recognize the signs and symptoms of human trafficking
Strongly Disagree   Disagree   Unsure   Agree   Strongly Agree

I can identify internal and external resources for human trafficking victims
Strongly Disagree   Disagree   Unsure   Agree   Strongly Agree

A 10 to 20-minute educational initiative increases my knowledge about human trafficking
Strongly Disagree   Disagree   Unsure   Agree   Strongly Agree

I endorse organization wide education about human trafficking
Strongly Disagree   Disagree   Unsure   Agree   Strongly Agree

I endorse organization wide screening for human trafficking
Strongly Disagree   Disagree   Unsure   Agree   Strongly Agree
Appendix F

Process Flow Chart- Screening for Human Trafficking

"Red Flag" Identified

YES

Provide Privacy and Comfort Measures

Ask Individual for Permission to Screen

Use Screening Tool with Individual Setting Pace

Assess Risk and Offer Appropriate Safety Plan and Resources

"Warm Handoff" if possible or facilitate direct connection of individual to external resource base

No Need to Screen but continue to assess for potential

NO

If Individual declines, stop and plan to re-attempt screening at a later time. Continue to attempt screening until patient is discharged

Provide Individual with Organizational Contact Information
Appendix G

Protocol for Human Trafficking

- Presents for medical care with care provided

  - "Red Flags" identified
    - Provide privacy and ask permission to screen for human trafficking
    - Collaborate with team to identify who should screen patient (RN/MD/LSW/other)
      Decision should be based on intention of creating the best trust-based relationship
    - Identify patient's goals of care and work with patient to meet those goals
      Respect patient's goals even when not aligned with goals of care team
    - Provide patient with desired resources and supports and create a patient-centered safety plan
    - Provide patient with a safe plan for follow-up prior to discharge
      Provide "warm handoff" when possible
  - Use brief open-ended screening tool with trauma-informed approach and allow patient to direct process as much as possible

  - No "red flags" identified
    - Provide usual care and continue to monitor for "red flags" until discharged
Appendix H

Suggested Screening Tool for Human Trafficking

1. Does anyone make you do anything that you do not want to do?  YES/NO

2. Do you have to do these things to stay safe or to make money for someone else or to keep your loved ones safe?  YES/NO

3. Have you ever felt forced to remain in a job situation due to fear of consequences from the employer or another person?  YES/NO

4. Do you feel afraid?  YES/NO

*If patient answer is YES to any question, patient should be taken immediately to private area for further evaluation of risk for human trafficking.*
Appendix I

Trafficking Victim Identification Tool (TVIT) Short Version

Date of interview: ______________________
Interviewer: ______________________
Demographic information: ______________________

_Screening purpose._ This screening tool is intended to be used as part of a regular intake process or as part of enrollment for specific programs. In order for the results to be valid, the screening should be administered according to pre-arranged protocols, whether or not the client is believed to be a victim of human trafficking. Please refer to the User Guide for directions on using this screening tool. _Screening timing._ Since each agency’s intake process is unique, agencies should determine how to best integrate this screening tool with their other intake forms or procedures. Whatever the timing and context of the interview, please begin and end with comfortable topics of conversation to minimize the client’s discomfort.

_Defered/Suspended Screening:_ In some cases, the intake process extends beyond the first meeting with the client. Service providers may sometimes choose to postpone sensitive screenings, judging that clients are not yet ready to disclose or discuss experiences of victimization and would prefer to continue the interview at a later date. If in the course of an interview the client shows acute signs of anxiety, ask the client if s/he would prefer to stop the interview and resume it at a later time.

The following are suggested basic demographic questions. You may wish to supplement these with your agency’s routine demographic or introductory questions.

Sex of client: female __________ male __________ other __________
Age/birth date of client: ______________________
Number of years of schooling completed: ______________________
Client’s preferred language: ______________________
Country of birth: ______________________

If client answers outside the U.S., please ask migration questions

_Migration:_

In what year was your most recent arrival to the U.S.? _____________ (YYYY)
If you don’t know exactly when you arrived in the U.S., about how long have you been here?
Less than 1 year
1 year
2 years
3 years
4 years
5 to 10 years
More than 10 years
If client has come to the U.S. more than once, you can ask them about other entries to the U.S. if relevant.

2. Did anyone arrange your travel to the U.S.? No Yes
   Can you tell me who? __________________________________________________________
   What did they do? ____________________________________________________________

3. Did you (or your family) borrow or owe money, or something else, to anyone who helped you come to the U.S.? No N/A Yes
   [INTERVIEWER: Probe for something else owed, such as property, a house, or land]
   Do you (or your family) still have this debt, or does anyone claim you do? No Yes
   [INTERVIEWER: Record volunteered information here]

4. If you did borrow or owe money, have you ever been pressured to do anything you didn’t want to do to pay it back? No N/A Yes
   If you are comfortable telling me, what kinds of things were you pressured to do that you didn’t want to do?
   Could you describe how you were pressured?

   Working/Living conditions

5. Have you worked for someone or done any other activities for which you thought you would be paid? No Yes
   [INTERVIEWER: This could include activities like unpaid domestic work that might not be readily defined as “work” and should only detail those jobs in which the person felt unsafe or did not get paid what the person felt he/she should.]
   What kind(s) of work or activities were you doing?
   How did you find out about these jobs/activities?
   [INTERVIEWER: probe for details, especially as they deal with recruitment from abroad]

6. Have you ever worked [or done other activities] without getting the payment you thought you would get? No Yes
   Was it the same work as you described above? No Yes
   What kind(s) of work or activities were you doing?
   [INTERVIEWER: You do not need to repeat “done other activities,” if unnecessary and the client understands work does not just mean formal work.]
What payment did you expect and why?

What did you receive?

7. Did someone ever (check all that apply):

- withhold payment from you
- give your payment to someone else
- control the payment that you should have been paid
- none of the above

[INTERVIEWER: Record volunteered information here]

8. Have you ever worked [or done other activities] that were different from what you were promised or told? No Yes ◊
What were you promised or told that you would do?

What did you end up doing?

9. Did anyone where you worked [or did other activities] ever make you feel scared or unsafe? No Yes ◊
Could you tell me what made you feel scared or unsafe?

10. Did anyone where you worked [or did other activities] ever hurt you or threaten to hurt you? No Yes ◊
[INTERVIEWER: This could include any physical, sexual, or emotional harm]
Could you tell me what they did or said? ______________________

11. Were you allowed take breaks where you worked [or did other activities], for example, to eat, use the telephone, or use the bathroom? No Yes ◊
What if you were sick or had some kind of emergency?

What did you think would happen if you took a break?

Did you have to ask for permission? No Yes ◊
What did you think would happen if you took a break without getting permission?

12. Were you ever injured or did you ever get sick in a place where you worked [or did other activities]? No Yes ◊

Were you ever stopped from getting medical care? No Yes ◊

If you feel comfortable, could you tell me more about what happened?

13. Have you ever felt you could not leave the place where you worked [or did other activities]? No Yes ◊

[INTERVIEWER: Probe for situations where someone threatened to do something bad if client tried to leave.]

Could you tell me why you couldn’t leave?

What do you think would have happened to you if you tried to leave?

14. Did anyone where you worked [or did other activities] tell you to lie about your age or what you did? No Yes ◊

Could you explain why they asked you to lie?

15. Did anyone where you worked [or did other activities] ever trick or pressure you into doing anything you did not want to do? No Yes ◊

If you are comfortable talking about it, could you please give me some examples?

16. Did anyone ever pressure you to touch someone or have any unwanted physical [or sexual] contact? No Yes ◊

If you are comfortable talking about it, could you tell me what happened?

17. Did anyone ever take a photo of you that you were uncomfortable with? No Yes ◊

If you feel comfortable talking about this, could you tell me who took the photo?

What did they plan to do with the photo, if you know?

[LAW ENFORCEMENT: If the respondent indicates that the photo was posted online, you should ask which website.]

Did you agree to this? No Yes

18. Did you ever have sex for things of value (for example money, housing, food, gifts, or favors)? No Yes ◊
[INTERVIEWER: Probe for any type of sexual activity]
Were you pressured to do this? No Yes ◊
Were you under the age of 18 when this occurred? No Yes
19. Did anyone take and keep your identification, for example, your passport or driver’s license? No Yes ◊
Could you get them back if you wanted? No Yes ◊
[INTERVIEWER: Probe for details]

______________________________________________________________________________

20. Did anyone where you worked [or did other activities] ever take your money for things, for example, for transportation, food, or rent? No Yes ◊
Did you agree to this person taking your money? No Yes ◊
Could you describe this situation?
______________________________________________________________________________

**Post-interview Assessment (to be completed by the interviewer)**
Note any nonverbal indicators of past victimization:
______________________________________________________________________________
______________________________________________________________________________

Note any indicators that responses may have been inaccurate:
______________________________________________________________________________
______________________________________________________________________________

Indicate the likelihood that the client is a victim of trafficking: certainly not likely not uncertain either way likely certainly. Briefly state up to three reasons for your rating:
(1) ____________________________________________________________
(2) ____________________________________________________________
(3) ____________________________________________________________

What kind of service referrals, if any, will you make for the client?
(1) ____________________________________________________________
(2) ____________________________________________________________
(3) ____________________________________________________________
(4) ____________________________________________________________
(5) ____________________________________________________________

**Additional Notes:**
______________________________________________________________________________
Appendix J

PEARR Tool
Trauma-Informed Approach to Victim Assistance in Health Care Settings

In partnership with HEAL Trafficking and Pacific Survivor Center, Dignity Health developed this tool, the “PEARR Tool”, to guide physicians, social workers, nurses, and other health care professionals on how to provide trauma-informed assistance to patients who are at high risk of abuse, neglect, or violence. The PEARR Tool is based on a universal education approach, which focuses on educating patients about abuse, neglect, or violence prior to, or in lieu of, screening patients with questions. The goal is to have an informative and normalizing, yet developmentally and culturally appropriate, conversation with patients in order to create a context for them to share their own experiences. A double asterisk ** indicates points at which this conversation may end. Refer to the double asterisk ** at the bottom of this page for additional steps. The patient’s immediate needs (e.g., emergency medical care) should be addressed before use of this tool.

P Provide Privacy

1. Discuss sensitive topics alone and in safe, private setting (ideally private room with closed doors). If companion refuses to be separated, then this may be an indicator of abuse, neglect, or violence.** Strategies to speak with patient alone: State requirement for private exam or need for patient to be seen alone for radiology, urine test, etc.

Note: Companions are not appropriate interpreters, regardless of communication abilities. If patient indicates preference to use companion as interpreter, see your facility’s policies for further guidance.**

Note: Explain limits of confidentiality (i.e., mandated reporting requirements) before beginning any sensitive discussion; however, do not discourage person from disclosing victimization. Patient should feel in control of all disclosures. Mandated reporting includes requirements to report concerns of abuse, neglect, or violence to internal staff and/or to external agencies.

E Educate

2. Educate patient in manner that is nonjudgmental and normalizes sharing of information. Example: “I educate all of my patients about [fill in the blank] because violence is so common in our society, and violence has a big impact on our health, safety, and well-being.” Use a brochure or safety card to review information about abuse, neglect, or violence, and offer brochure/card to patient. [Ideally, this brochure/card will include information about resources (e.g., local service providers, national hotlines)]. Example: “Here are some brochures to take with you in case this is ever an issue for you, or someone you know.” If patient declines materials, then respect patient’s decision.**

A Ask

3. Allow time for discussion with patient. Example: “Is there anything you’d like to share with me? Do you feel like anyone is hurting your health, safety, or well-being?”** If available and when appropriate, use evidence-based tools to screen patient for abuse, neglect, or violence.**

Note: All women of reproductive age should be intermittently screened for intimate partner violence (USPSTF Grade B)

Note: Limit questions to only those needed to determine patient’s safety to connect patient with resources (e.g., trained victim advocates) and to guide your work (e.g., perform medical exam).

USPSTF = US Preventive Services Task Force

4. If there are indicators of victimization, ASK about concerns. Example: “I’ve noticed [insert risk factor/indicator] and I’m concerned for your health, safety, and well-being. You don’t have to share details with me, but I’d like to connect you with resources if you’re in need of assistance. Would you like to speak with [insert advocate/service provider]? If not, you can let me know anytime.”**

R R Respect and Respond

5. If patient denies victimization or declines assistance, then respect patient’s wishes. If you have concerns about patient’s safety, offer hotline card or other information about resources that can assist in event of emergency (e.g., local shelter, crisis hotline).** Otherwise, if patient accepts/requests assistance with accessing services, then provide personal introduction to local victim advocate/service provider; or, arrange private setting for patient to call hotline:

National Domestic Violence Hotline, 1-800-799-SAFE (7233);
National Sexual Assault Hotline, 1-800-656-HOPE (4673);
National Human Trafficking Hotline, 1-888-373-7888 **

** Report safety concerns to appropriate staff/departments (e.g., nurse supervisor, security). Also, REPORT risk factors/indicators as required or permitted by law/regulation and continue trauma-informed health services. Whenever possible, schedule follow-up appointment to continue building rapport and to monitor patient’s safety/well-being.
### Adult Human Trafficking Screening Tool

This screening tool is part of a guide and is to be used with the “Adult Human Trafficking Screening Tool and Guide.” It has been provided as part of a screening toolkit to a professional who is trained to administer it. For information about this screening tool or the recommended training for its application, please contact the National Human Trafficking Training and Technical Assistance Center (NHTTAC) at info@nhttac.org or 844–648–8822.

<table>
<thead>
<tr>
<th>Question</th>
<th>Respondent Answers</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>1. Sometimes lies are used to trick people into accepting a job that doesn’t exist, and they get trapped in a job or situation they never wanted. Have you ever experienced this, or are you in a situation where you think this could happen?</td>
<td>Yes</td>
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<td>No</td>
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<td>Declined to Answer</td>
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<td>2. Sometimes people make efforts to repay a person who provided them with transportation, a place to stay, money, or something else they needed. The person they owe money to may require them to do things if they have difficulty paying because of the debt. Have you ever experienced this, or are you in a situation where you think this could happen?</td>
<td>Yes</td>
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<td>No</td>
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<td>Don’t Know</td>
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<td>3. Sometimes people do unfair, unsafe, or even dangerous work or stay in dangerous situation because if they don't, someone might hurt them or someone they love. Have you ever experienced this, or are you in a situation</td>
<td>Yes</td>
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<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
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<td>4. Sometimes people are not allowed to keep or hold on to their own identification or travel documents. Have you ever experienced this, or are you in a situation where you think this could happen?</td>
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<td>5. Sometimes people work for someone or spend time with someone who does not let them contact their family, spend time with their friends, or go where they want when they want. Have you ever experienced this, or are you in a situation where you think this could happen?</td>
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<tr>
<td>6. Sometimes people live where they work or where the person in charge tells them to live, and they’re not allowed to live elsewhere. Have you ever experienced this, or are you in a situation where you think this could happen?</td>
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<td>7. Sometimes people are told to lie about their situation, including the kind of work they do. Has anyone ever told you to lie about the kind of work you’re doing or will be doing?</td>
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<tr>
<td>8. Sometimes people are hurt or threatened, or threats are made to their family or loved ones, or they are forced to do</td>
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things they do not want to do in order to make money for someone else or to pay off a debt to them. Have you ever experienced this, or are you in a situation where you think this could happen?

If the client/patient answered YES to any of the questions, this may indicate a risk for current, former, or future trafficking. If you feel this individual is at risk, or is being trafficked, discuss referral options, including possibly reporting to the appropriate authorities trained on human trafficking. Ask, “do you want additional resources or information?” For assistance with referrals or other resources, please contact the National Human Trafficking Hotline: 1–888–373–7888, 24/7 (200 languages).