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Implementation of a Human Trafficking Response Protocol in a Reproductive Healthcare Setting: The Impact on Clinician Preparedness

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Abstract

Background. The healthcare setting is one of the most promising places to identify victims of human trafficking. However, healthcare providers may be unsuccessful in recognizing human trafficking victims due to a lack of knowledge, awareness, and confidence in their ability to intervene. The purpose of this quality improvement project was to evaluate the impact of implementing a human trafficking response protocol on clinician preparedness and practices surrounding the identification, assessment, and response to victims of human trafficking presenting for medical care in a reproductive healthcare organization.

Methods. A human trafficking response protocol was introduced to clinicians via a 30-minute webinar. A prospective, quasi-experimental, one group, pre-test/post-test survey design was used to assess changes in self-reported preparedness and to examine changes in clinician screening practices two weeks pre-intervention and one month after implementation of the protocol. Independent samples *t*-tests were used to compare pre- and post-intervention results.

Results. Statistically significant ($p < 0.05$) increases on all measures of clinician self-reported preparedness and frequency of asking screening questions when a warning sign of human trafficking was present were achieved.

Conclusions. Implementation of a human trafficking response protocol positively impacted clinician preparedness to identify, assesses, and respond to victims of human trafficking and increased the frequency of clinician screening for trafficking when a warning sign was present. These findings suggest that a human trafficking protocol may be an important tool to improve clinician practices around human trafficking and further work to develop and disseminate evidence-based protocols to healthcare organizations should be a priority area for intervention.

Keywords: human trafficking; healthcare protocol; healthcare provider education; intervention

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Human trafficking is a form of modern day slavery and is considered one of the most pressing global human-rights, law-enforcement, and public health issues (Stoklosa, Showalter, Melnick, & Rothman, 2016). Human trafficking is defined as, "the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery" (United States Department of State, 2017, p. 3) and is primarily characterized by the appropriation, control, and exploitation of humans for profit (Macias-Konstantopoulos, 2016). Although establishing the true levels of prevalence of human trafficking has proven extremely challenging due to the criminal nature of the activity and trafficked victims' reluctance to identify themselves, it is estimated that 25 million people are trapped in forced manual or sexual labor worldwide (International Labor Organization, [ILO], 2017). Of those 25 million people, 4.9 million are victims of forced sexual exploitation (ILO, 2017). Women and girls are disproportionately affected and represent 99% of victims of forced labor in the commercial sex industry (ILO, 2017). Human trafficking has been declared the second largest criminal enterprise in the world and generates an estimated 150 billion United States dollars (USD) in illegal profits annually (ILO, 2014). In the United States, suspected cases of human trafficking have been reported in all 50 states with the National Human Trafficking Resource Center (NHTRC) documenting the receipt of 31,659 phone calls reporting trafficking activity from 2007-2016 (NHTRC, 2017).

Human trafficking impacts victims in multiple, profound, and long-lasting ways. Victims almost universally suffer from a wide range of physical, reproductive, and mental health

problems due to poor working conditions, abuse, and trauma (Lederer & Wetzel, 2014; Oram Stockl, Busza, Howard, & Zimmerman, 2012). Health problems associated with human trafficking include: traumatic injuries, untreated chronic diseases, poor oral health, gynecological injuries, sexually transmitted infections, unplanned pregnancy, repeated or forced abortion, affective disorders (anxiety, depression, and panic attacks), posttraumatic stress disorder, sleep disorders, low self-esteem, accidental death, and an increased risk of suicide both during and after the trafficking experience (Macias-Konstantopoulous, 2016; Lederer & Wetzel, 2014; Oram et al., 2012). In addition, human trafficking has important public health implications for the spread of human immunodeficiency virus (HIV) and other communicable diseases, the rising epidemic of substance use disorders, and the profound effects of serious mental illness which resound beyond the individual to affect all of society (Macias-Konstantopoulos, 2016).

The healthcare setting is thought to be one of the most promising places to identify victims of human trafficking (Stoklosa et al., 2017) because, despite the high degree of control exerted over victims by perpetrators, survivors repeatedly report having received medical care while being trafficked (Lederer & Wetzel, 2014; Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011, Chisolm-Straker et al., 2016). One study of female survivors found that 87.8% had accessed medical care during their trafficking experience (Lederer & Wetzel, 2014). The two most common points of health care cited in the study were an emergency department (60%) and a Planned Parenthood clinic (29.6%) (Lederer & Wetzel, 2014). Responses indicated that a significant number of trafficking victims saw a healthcare provider to obtain birth control without trafficker supervision. This suggested a rare opportunity for clinicians providing these services to intervene; however, no survivors in the study were identified by a medical provider as being trafficked (Lederer & Wetzel, 2014).

Healthcare professionals interacting with trafficked individuals are in a unique position to disrupt the trafficking cycle (Bespalova, Morgan, & Coverdale, 2016). However, clinicians are often underprepared to identify and respond to victims of human trafficking due to a low level of awareness and lack of education and training (Chisholm-Straker, Richardson, & Cossio, 2012; Ross et al., 2015). In addition, a lack of organizational policies and/or protocols to guide an appropriate response following disclosure is a barrier to clinician readiness to respond to victims and to assist them to leave the exploitive situation (Macias-Konstantopoulous, 2016; Recknor, Gemeinhardt, & Selwyn, 2017). Without adequate knowledge of human trafficking and established policies and protocols to guide the response, providers may not know how to proceed or may hesitate to respond for fear of not being able to help the victim or fear of triggering a reactionary response that is harmful to the patient (Macias-Konstantopoulous, 2016). Furthermore, gaps in knowledge contribute additional barriers to the identification and response to victims and include: (a) lack of a screening tool for victim identification that has been validated in a health care setting (Bespalova et al., 2014); (b) lack of a standardized, readily available, and rigorously evaluated educational curriculum for health care provider training (Stoklosa et al., 2017); and (c) lack of a standardized guideline for immediate response by service providers once a trafficking victim is identified (Macy & Graham, 2012).

Given the prevalence and wide geographic distribution of human trafficking in the U.S, clinicians working in a reproductive health care setting need to have knowledge of the scope of human trafficking, risk factors for victimization, and how to identify victims. In addition, clinicians must be equipped with the skills to diagnose, treat, and refer victims of trafficking for services (Institute of Medicine and National Research Council, 2013). By failing to identify and properly respond to victims, providers are unwittingly contributing to continued victimization

and criminal activity and thus exacerbating both physical and mental health problems for this vulnerable population (Lederer & Wetzel, 2014).

Preparedness to identify, assess, and respond to victims of human trafficking requires that clinicians are both knowledgeable about human trafficking and equipped with tools to guide them through the complex interactional process (Tracy & Macias-Konstantopoulos, 2017). Therefore, the implementation of a human trafficking response protocol is a solution to improve the preparedness of clinicians to identify, assess, and respond to victims of human trafficking presenting for medical care in a reproductive health care organization in the Midwest, United States.

Critical Review of Pertinent Literature

In September 2017, CINAHL, MEDLINE, PsyINFO, and SocINDEX databases were searched using the keywords: *human trafficking* AND *knowledge* OR *human trafficking* AND *identification* OR *human trafficking* AND *training* OR *human trafficking* AND *response* OR *human trafficking* AND *education* OR *human trafficking* AND *response*. The search was limited to peer-reviewed, English-language, journal articles from the Unites States published from 2012-2017. The initial search yielded 74 articles. All titles were reviewed, and 38 articles were excluded because they did not relate specifically to human trafficking. Journal articles that met the following inclusion criteria were included in the review:

- Empirical research studies on human trafficking whose primary purpose is to study victim presentation in health care settings, victim identification, and health care professional awareness or education in the subject of human trafficking.
- Empirical research studies focused on educational or protocol intervention in an inpatient or outpatient health care setting.

- Review articles focused on the examination of current literature regarding victim presentation in a health care setting, victim identification, and health care professional awareness or education about human trafficking.

Journal articles with the following characteristics were excluded from the review.

- Journal articles with a purpose to educate or offer general information or guidance for health professionals on their role in managing human trafficking.
- Journal articles with a purpose to provide descriptive data, case study data, or evaluate interventions within specific sub-population risk groups.
- Journal articles focused on the description of governmental or organizational policy.
- Journal articles with a purpose to evaluate survey tools.
- Journal articles with a purpose to discuss conceptual models.

Titles and abstracts were reviewed for the remaining 36 articles. Five articles from the search met the study inclusion criteria, and an additional seven articles were identified from key references. Finally, one article was located by a keyword search within an online specialty journal that came to the author's attention during project preparation.

The key themes that emerged from the literature concerned: the under-identification of victims, the lack of subject knowledge of healthcare providers, and the positive effect of human trafficking training on healthcare provider knowledge and skill. Each is discussed in detail below.

Difficulty of Victim Identification

Three studies described the phenomena of the difficulty of identifying human trafficking victims in the healthcare setting (Chisolm-Straker et al., 2016; Baldwin et al, 2011; Lederer & Wetzel, 2014). In each study, most participants sought healthcare from a provider while being

trafficked with percentages ranging from 50% of survivors in a small (n = 10) qualitative study (Baldwin, et al., 2011) to 87.8% in a larger (n=106) study utilizing a mixed data collection approach of interview and survey questions (Lederer & Wetzel, 2014). Victim identification in the healthcare setting was low in all three studies and ranged from zero victims specifically being identified as trafficked (Lederer & Wetzel, 2014; Baldwin et al., 2011) to a 44% identification rate reported in a retrospective survey of 173 survivors (Chisolm-Straker et al., 2016). These studies demonstrate that victims are commonly presenting for medical care but are not being consistently identified by healthcare providers.

Healthcare Provider Awareness, Knowledge, and Confidence

Surveys of healthcare providers consistently show low levels of awareness, knowledge, and confidence regarding identification and treatment of victims (Chisolm-Straker et al., 2012; Ross et al., 2015; Konstantopoulos et al., 2013). In addition, many health professionals are reluctant to actively pursue identification and to intervene in trafficking situations (Konstantopoulos et al., 2013).

In a survey of 782 health professionals working for the National Health Service in England, Ross et al. (2015) found levels of perceived knowledge about how to identify and respond to potential victims were low with 60.2% of subjects reporting very little knowledge of their role in responding to victims, asking appropriate screening questions, knowing what to say or not say to a victim, documenting the encounter, assessing danger, and identifying national and local support services. In addition, most providers did not feel confident making appropriate referrals for trafficked women (69%), men (73%), and children (55%). Eighty percent reported they had not received sufficient training to enable them to assist victims of trafficking (Ross et al., 2015). Similarly, a descriptive survey of 180 emergency department (ED) health care

providers in the Western U.S. showed most respondents were hesitant or not confident in their ability to identify a victim of human trafficking or to correctly treat a victim of human trafficking in the ED (Chisolm-Straker et al., 2012). Nearly all respondents (97.8%) reported never receiving formal training on the clinical presentation of trafficking victims, and 95% reported never receiving formal training on the treatment of victims of human trafficking (Chisolm-Straker et al., 2012). Lack of training and awareness have been cited as the greatest barrier to victim identification (Beck et al., 2015) and the literature consistently demonstrates the need for human trafficking training for healthcare providers to improve their awareness, knowledge, and ability to recognize and treat victims.

Interventions

Participation in trafficking-related trainings has shown to be significantly and positively associated with clinicians' levels of human trafficking knowledge and awareness and with the ability to identify trafficking cases in human services providers (Hounmenou, 2012; Beck et al., 2015). However, there is a dearth of interventional studies that have examined these variables. The current search identified just four such studies. Grace et al. (2014) conducted the only empirical study using a group randomized control design with a delayed intervention comparison group to determine the effect of a 20-minute educational intervention on: knowledge of human trafficking, self-rated knowledge of human trafficking, knowledge of who to call for potential victims, and suspecting that a patient was a victim of human trafficking in a group (n=258) of participants that worked in an ED. Outcomes were measured by pre-test and post-test survey and showed that the educational intervention significantly increased knowledge about human trafficking and what to do about a potential victim when compared to a delayed intervention comparison group ($\boldsymbol{p} < 0.001$). In addition, there was a statistically significant shift in the

percentage of providers in the intervention group who suspected a victim of human trafficking among their patients ($p < 0.001$). The researchers concluded that the increased recognition of possible victims in the intervention group suggested that education may improve the identification of human trafficking victims (Grace et al., 2014). Similar positive outcome effects were demonstrated by Chisolm-Straker et al. (2012) following a 20-minute didactic training session targeting 104 health care professionals. The descriptive survey queried providers on their confidence defining human trafficking, identifying a victim of human trafficking, and treating a victim of human trafficking pre-and post-intervention. Proportions on all outcome measures increased following the training session (Chisolm-Straker et al., 2012). Study authors acknowledge that it is unknown if the educational intervention changed providers' care methods or had a positive effect on patient care (Chisolm-Straker et al., 2012).

Stocklosa, Showalter, Melnick, and Rothman (2016) and Egyud, Stephens, Swanson-Bierman, DiCuccio, and Whiteman (2017) examined outcomes following the implementation of a protocol or algorithm that guided victim identification and provider response. Health system employees were interviewed to gather information about the development and implementation of a healthcare system protocol for identifying, referring, and treating victims of human trafficking (Stoklosa et al., 2016). The qualitative analysis revealed that, although protocol development was challenging, the protocol was easy for clinicians to use and improved clinician ability to identify victims, confidence in their ability to assess patients, and made them more mindful of the possibility that they were seeing trafficking victims in their practice setting (Stoklosa et al., 2016). However, the generalizability of this study was limited by its small sample size ($n = 10$) and the subjective nature of opinions shared by participants (Stocklosa et al., 2016). Egyud et al. (2017) implemented a screening system and treatment algorithm to improve the identification

and rescue of human trafficking victims in an ED. Participants completed a mandatory training session that included information about the screening tool, medical red flags, resources for rescue, and plans for notification of appropriate agencies. Attendees were provided with a tip sheet for clinical use following the session. Surveys were completed by 102 employees and showed that most participants (74%) perceived that the education improved their competence (Egyud et al., 2017). Five months after implementation, protocol compliance was assessed via an electronic health record audit and found to be 100%. In addition, a total of 38 potential trafficking victims were identified, five accepted being rescued from a domestic abuse situation, and one was found to be a victim of trafficking. The authors report this as a significant finding because no human trafficking victims had been identified in the study setting prior to intervention implementation (Egyud et al., 2017). These studies support that implementing protocols or guidelines in healthcare settings positively impact healthcare providers' confidence and ability to identify and respond to victims of human trafficking.

The current state of the literature on identifying and responding to human trafficking in the healthcare setting highlights the lack of empirical evidence to support identification, care, and referral of victims in healthcare settings (Hemmings et al., 2016) and the lack of how service providers might identify trafficking victims that they are likely to encounter in the healthcare setting (Macy & Graham, 2012). Researcher have suggested that implementation of a guideline or protocol may improve identification and response to victims of human trafficking (Hemmings et al., 2016; Macias-Konstantopoulos, 2016); however, there is a gap in knowledge as only two studies have examined outcomes related to guideline or protocol use (Stoklosa et al., 2016; Egyud et al., 2017).

Purpose

The purpose of this quality improvement project was to evaluate the impact of implementing a human trafficking response protocol on clinician preparedness and practices surrounding the identification, assessment, and response to victims of human trafficking presenting for medical care in a reproductive healthcare setting. *Human trafficking response protocol* was defined as a written document that detailed a set of indicators of possible victimization that clinicians should consider when assessing every patient, recommended screening questions to ask when an indicator was present, and a series of steps to be followed when a clinician suspected the patient may be a victim of human trafficking.

This Doctor of Nursing Practice (DNP) project answered two questions. First, did implementing a human trafficking response protocol impact clinician preparedness to identify, assess, and respond to victims of human trafficking? Second, did implementing a human trafficking response protocol impact the frequency of clinician screening for human trafficking when a warning sign of trafficking was present?

Theoretical Foundation

Normalization Process Theory (NPT) was used to direct implementation of this DNP project. NPT is a middle range, sociological theory that helps to guide understanding about how and why things become – or don't become – routine and normal components of everyday work by providing a set of sociological tools to understand and explain the social processes that frame the implementation of practices (May & Finch, 2009). NPT is considered an implementation theory and can be used to facilitate understanding of the practical issues involved in embedding interventions into routine clinical practice (May & Finch, 2009). NPT is concerned with the social organization of the work (implementation), of making practices routine (embedding), and

of sustaining embedded practices (integration) (May & Finch, 2009). The theory also focuses on factors that can promote or inhibit each of these behaviors.

The work of implementation is operationalized through four interrelated mechanisms that serve as the theory's core constructs. The constructs explain how people work together and what people do when implementing a practice. First, coherence is the individual and group understanding of a practice and serves to define and organize the components of an intervention, where coherence is described as the sense-making of the work (May et. al, 2009). Second, cognitive participation is the engagement of individuals and groups with a practice, defines and organizes the people implicated in an intervention, and is also known as the participation work (May & Finch, 2009). Third, collective action is the interaction of a process with already existing practices and refers to doing the actual work needed to complete a practice. Collective action organizes the execution of a complex intervention and describes what users do to enact a new practice (May & Finch, 2009). Finally, reflexive monitoring is how a practice is understood and assessed by the individuals participating with it and defines and organizes assessment of the outcomes of a complex intervention (May & Finch, 2009). Reflexive monitoring is commonly operationalized as what users do to appraise the effects of a new practice.

Using NPT to plan a process improvement project may enhance the understanding of barriers to implementation and enhance the ability to design interventions to improve implementation processes (McEvoy et al., 2014). Researchers have suggested that interventions that focus on collective action and reflexive monitoring are the most successful in promoting professional behavioral change (Johnson & May, 2015). Therefore, to integrate the human trafficking response protocol successfully into clinician practice, the four social mechanisms of

NPT were considered with special attention paid to specific implementation interventions that promoted development of collective action and reflexive monitoring.

Methods

Project Setting

The project was implemented at a reproductive healthcare organization in the Midwestern U.S. The organization operates 19 clinics located in urban, suburban, and rural settings and provides clinical services to approximately 65,000 persons annually. Services include contraceptive care, preventative health examinations, testing and treatment of sexually transmitted infections, gynecologic examinations, abortion services, and sexual health education for adolescents, women, and men. The organization provides care to a large proportion of uninsured and underinsured patients with nearly half of patients having incomes at or below 100% of the federal poverty level. In addition, over 70% of patients are eligible for family planning assistance, and over 35% of patients qualify for Medicaid reimbursement. In the study setting, there was no organizational protocol currently in place for identifying or responding to victims of human trafficking. However, all staff members were required to complete a 30-minute online educational module on human trafficking annually as part of competency training.

Participants and Recruitment

Participants for this project were drawn from a convenience sample of 49 clinicians employed by the reproductive healthcare organization. In the context of this project, *clinician* was defined as a nurse practitioner (NP), certified nurse midwife (CNM), or physician assistant (PA) who was directly involved in the assessment, diagnosis, and treatment of patients presenting for medical care. Inclusion criteria for participation included: full time, regular part time, and per diem employment in the organization, willing to consent for participation,

completion of the 30-minute webinar, and submission of the pre- and post-intervention surveys. The principal investigator was excluded from participation.

The principal investigator sent a participant recruitment email via a clinician email distribution list which included all clinicians employed at the reproductive healthcare organization. A second recruitment email was sent one week later. The participant recruitment emails briefly explained the project, invited participation, and included a hyperlink to begin the pre-intervention survey. After choosing to activate the hyperlink, the participant was redirected to the Survey Monkey© (Palo Alto, CA) landing page which included the Informed Consent Statement. The participant had options at this point to proceed with the pre-intervention survey or to opt out of participation. Completion of the anonymous, online pre-intervention survey served as participant consent for the research project. Attending the educational webinar was not contingent on participation in the project, which was voluntary.

Design

A prospective, quasi-experimental, one group, pre-test/post-test design was used to assess changes in self-reported preparedness to identify, assess, and respond to actual and potential victims of human trafficking and to examine changes in clinician screening practices when a warning sign of human trafficking was present, two weeks pre-intervention and one month after implementation of a human trafficking response protocol (see Appendix A). The DNP scholarly project was approved by the University of North Dakota Institutional Review Board (IRB) and received Medical Director approval from the clinical agency. The pre- and post-intervention online survey response data were collected in aggregate form. Identifiable participant information such as e-mail addresses, participant names, or IP addresses were not linked to the participants' answers. Data were downloaded from the Survey Monkey© website to a password

protected portable storage device that was only accessible to the primary investigator and will be stored in a secure location for three years.

Procedure for Implementation

Development of the intervention. The human trafficking response protocol was a written document that detailed a set of indicators of possible victimization that providers should consider when assessing every patient, recommended screening questions to ask when an indicator was present, a series of steps to be followed when a clinician suspected that the patient was a victim of human trafficking and contact information for appropriate referral agencies. The indicators, screening questions, steps, and three referral options were outlined on a color-coded, two-sided document for ease of use (Appendix B).

Because there were no published screening or response protocols that had been validated for use in a healthcare setting at the time of this project implementation, the human trafficking response protocol was developed by the principal investigator based on models published by other healthcare systems (Via Christi Health, 2016; Boston Medical, 2016), national human trafficking resources (Polaris Project, 2010; NHTRC, 2016), and published literature (Macias-Koststantopoulos, 2016; Stoklosa, Dawson, Williams-Oni, & Rothman, 2017). The protocol was tailored to the reproductive healthcare organization and vetted by the Medical Director, Clinician Director, Licensed Clinical Social Worker, and Deputy General Counsel/Chief Compliance Officer prior to implementation.

Implementing a human trafficking protocol without proper staff education and training may put the victim, healthcare professional, and other persons in the environment into danger (Stoklosa et al., 2016). Additionally, educational meetings have been shown to promote adoption of new clinical practices by promoting NPT constructs of coherence, cognitive

participation, and collective action (Johnson & May, 2015). Therefore, the human trafficking response protocol was introduced to clinicians via a 30-minute educational webinar.

Educational webinar was defined as an online meeting during which information was shared and participating viewers could submit questions and comments and interact with the facilitator. The purposes of the educational webinar were to: (a) present information about human trafficking to form a context for the intervention; (b) provide information on utilizing a trauma-informed approach to support disclosure and prevent revictimization; and (c) introduce and inform the use of the human trafficking response protocol. The webinar content was developed from an evidence-based framework that recommended eight primary content areas for inclusion within an education program: introduction, barriers, recognition, rapport building, rapport building pitfalls, interventions, referral, and documentation (Miller, Duke, & Northam, 2016). The specific learning objectives for participants to achieve following the webinar were:

- Describe human trafficking and the common risk factors for victimization.
- Understand the prevalence of human trafficking in our communities.
- Recognize possible indicators of human trafficking.
- Describe the role of the health care provider in combatting human trafficking.
- Demonstrate how to use the human trafficking response protocol to identify and respond to potential trafficking victims.

Data Collection. Participation in this DNP project included the completion of a pre-intervention survey, attendance at a 30-minute educational webinar describing the use of the human trafficking response protocol, and the completion of a post-intervention survey between January 2018 and April 2018. A participant recruitment email introducing the project, informing staff of the dates of the educational webinar, and containing a hyper-link to a computer-based

pre-intervention survey was sent to every clinician in the healthcare organization via a group distribution list. In the pre-intervention survey, the clinician was asked questions related to demographics, previous human trafficking educational preparation, self-perceived level of preparation for identifying, assessing, and responding to victims of human trafficking, and clinical practices surrounding screening for human trafficking (Appendix C). The pre-intervention survey remained accessible to participants for two weeks.

Following closure of the pre-intervention survey, two meeting invitations (one for each webinar session) were sent to every clinician in the healthcare organization via a group distribution list. Each invitation included the date, time, and a hyper-link to access the educational webinar session that was conducted via the GlobalMeet© portal one week after the closure of the pre-intervention survey. A copy of the human trafficking response protocol was attached to the meeting invitation. The second educational webinar session was recorded, and a hyper-link to the recording was sent to every clinician in the healthcare organization via a group distribution list on the day after the live session was completed. This webinar recording remained accessible to clinicians for two weeks. Following completion of the second webinar session, laminated copies of the human trafficking response protocol were mailed to each clinic manager via U.S. postal mail for distribution to clinician staff.

One month after the educational webinar session, a hyper-link to a computer-based post-intervention survey was emailed to every clinician via a clinician distribution list. Post-intervention survey questions were related to self-perceived level of preparation for identifying, assessing, and responding to victims of human trafficking and clinical practices surrounding screening for human trafficking and questions regarding study participation (Appendix D). The post-intervention survey remained accessible to participants for two weeks.

Measures

A 27-item online survey was administered prior to implementation of the educational webinar and the human trafficking response protocol, and a 22-item online survey was administered following the educational webinar and implementation of the human trafficking response protocol. The surveys were designed to assess participant preparedness to identify, assess, and respond to human trafficking and to examine practices surrounding the identification and management of victims of human trafficking. The surveys included items modified from a previously developed and validated questionnaire "A Tool for Measuring Physician Readiness to Manage Intimate Partner Violence" (Short, Alpert, Harris Jr., & Suprenant, 2006). On both surveys, a ten-item subscale was used to evaluate clinicians' self-perceived preparedness to identify, assess, and respond to human trafficking on a seven-point Likert scale ranging from "not prepared" to "quite well prepared". In addition, an eight-item subscale evaluated the practice behaviors of clinicians by assessing the frequency that the clinician had asked about the possibility of human trafficking when a warning sign of human trafficking had been present on a five-point Likert scale ranging from "never" to "nearly always". A not applicable (N/A) category was included for use if the clinician had not seen a patient demonstrating the warning sign over the indicated time frame. One question evaluated the perceived presence and use of a protocol: "Is there a protocol for dealing with human trafficking in your practice?". Five available responses ranged from "unsure" to "yes, and widely used". One question evaluated the perceived adequacy of available referral resources: "Do you feel you have adequate human trafficking referral resources for patients at your clinic?". Three available responses included "unsure", "yes", and "no". Additional covariates measured on the pre-intervention survey include demographic data: gender, age, ethnicity, specialty certification, years as a clinician,

years employed at organization; and the amount of previous, formal human trafficking training that the clinician had received. Finally, the post-intervention survey included two questions to assess study participation: "Did you attend a live presentation or view a recording of the webinar that introduced and explained the human trafficking response protocol?", and "Did you complete the online human trafficking survey before attending or viewing a recording of the webinar?".

Outcomes

The goal of this project was to improve the identification, assessment, and response to victims of human trafficking presenting for medical care in a reproductive healthcare setting. The successful achievement of this goal was measured by two primary outcomes:

1. Participants will report a statistically significant increase in preparedness to identify, assess, and respond to victims of human trafficking as evidenced by comparison data from a pre- and post-intervention Likert scale survey.
2. Participants will report a statistically significant increase in frequency of screening for human trafficking when a warning sign is present as evidenced by comparison data from a pre- and post-intervention Likert scale survey.

In addition, two secondary outcomes were measured:

1. Ninety percent (90%) or greater of participants will report that the human trafficking response protocol is widely used in their practice as evidenced by post-intervention survey.
2. Ninety percent (90%) or greater of participants will report that they have adequate human trafficking victim referral resources at their clinic site as evidenced by post-intervention survey.

Data Analysis

Data were analyzed with IBM® SPSS® Statistics Version 24.0. Descriptive analyses, including frequencies and mean values, were conducted on the demographic, pre-test, and post-test items. Differences in self-reported preparedness to identify, assess, and response to victims of human trafficking and the frequency of screening for human trafficking when a warning sign was present before and after the intervention were examined using independent samples *t*-tests at a significance level of 0.05.

Results

The purpose of this quality improvement project was to evaluate the impact of implementing a human trafficking response protocol on clinician preparedness and practices surrounding the identification, assessment, and response to victims of human trafficking presenting for medical care in a reproductive healthcare setting.

Demographics

Twenty-three clinicians completed the pre-intervention survey and 22 clinicians completed the post-intervention survey. Of these clinicians, 17 (77.2%) completed the pre- and post-intervention surveys as well as the educational webinar. Table 1 displays the demographics of the sample. Participants were female (100%) with the majority (78.3%) aged 25-44 years of age. Most participants were white/Caucasian (87.0%). Specialty certification of the respondents included: Women's Health Care Nurse Practitioner (52.2%), Certified Nurse Midwife (17.4%), Family Nurse Practitioner (13.0%), Adult/Gerontological Nurse Practitioner (8.7%), and Physician Assistant (8.7%). The mean time of practice in the specialty certification was 8.09 (SD 9.99) years and the mean length of employment within the reproductive health care

organization was 5.03 (SD 4.93) years. Subjects reported receiving a mean of 4.98 (SD 6.62) hours of previous training on the topic of human trafficking.

Table 1

Study Participant Characteristics (n=23)

Characteristic	**Category**	**n (%)**
Gender	female	23 (100)
Age (years)	25 to 34	10 (43.5)
	35 to 44	8 (34.8)
	45 to 54	3 (13.0)
	55 to 64	1 (4.3)
	65 to 74	1 (4.3)
Race/Ethnicity	Black/African-American	1 (4.3)
	Hispanic/Latino	2 (8.7)
	White/Caucasian	20 (87.0)
Specialty Certification	Women's Health Care Nurse Practitioner	12 (52.2)
	Family Nurse Practitioner	3 (13.0)
	Adult/Gerontological Nurse Practitioner	2 (8.7)
	Certified Nurse Midwife	4 (17.4)
	Physician Assistant	2 (8.7)
	Mean	**SD**
Length of time practicing in the specialty certification (years)	8.09	9.96
Length of time employed by the health care organization (years)	5.03	4.93
Amount of previous training on human trafficking received (hours)	4.98	6.62

Preparedness

One month after implementation of the human trafficking response protocol, there was a statistically significant increase in clinician self-reported preparedness to identify, assess, and respond to victims of human trafficking on each of the 10 preparedness items (Table 2).

Table 2

Changes in self-reported preparedness to identify, assess, and respond to victims of human trafficking

Measure of Preparedness	Survey Period	Mean	Standard Deviation	Mean Difference	Level of Significance
Identify HT indicators based on patient history and physical examination	Pre-Intervention Post-Intervention	3.59 5.31	1.221 1.138	-1.722	.000
Help a HT victim assess their safety	Pre-Intervention Post-Intervention	3.50 5.00	1.336 1.317	-1.500	.001
Assess a HT victim's readiness to change	Pre-Intervention Post-Intervention	3.00 5.00	1.512 1.265	-2.000	.000
Ask patients appropriated questions about HT	Pre-Intervention Post-Intervention	3.18 4.94	1.296 .998	-1.756	.000
Appropriately respond to disclosures of HT	Pre-Intervention Post-Intervention	2.91 5.13	1.342 1.088	-2.216	.000
Utilize a trauma-informed approach when interacting with victims of HT	Pre-Intervention Post-Intervention	2.41 4.75	1.368 1.342	-2.341	.000
Help a HT victim create a safety plan	Pre-Intervention Post-Intervention	2.59 4.69	1.297 1.493	-2.097	.000
Document HT history and physical exam	Pre-Intervention Post-Intervention	2.91 5.31	1.716 1.195	-2.403	.000
Make an appropriate referral for a victim of HT	Pre-Intervention Post-Intervention	2.50 5.19	1.185 1.328	-2.688	.000
Fulfill state reporting requirements for HT	Pre-Intervention Post-Intervention	2.14 4.81	1.246 1.377	-2.676	.000

Frequency of Screening

One month after implementation of the human trafficking response protocol, there was a statistically significant increase in the self-reported frequency of clinician screening for each of the eight human trafficking warning sign items (Table 3).

Table 3

Changes in self-reported screening frequency when a warning sign of human trafficking was present.

Warning Sign	Survey Period	Mean	Standard Deviation	Mean Difference	Level of Significance
High number of sexual partners	Pre-Intervention Post-Intervention	2.50 3.41	1.221 1.138	-.912	.011
Inconsistent or scripted history	Pre-Intervention Post-Intervention	2.35 4.29	1.336 1.317	-1.941	.000
Multiple pregnancies or abortions	Pre-Intervention Post-Intervention	2.17 3.59	1.512 1.265	-1.422	.008
Accompanied by a controlling person	Pre-Intervention Post-Intervention	2.62 4.47	1.296 .998	-1.852	.001
Multiple sexually transmitted infections	Pre-Intervention Post-Intervention	2.29 3.65	1.342 1.088	-1.361	.004
Hyper-vigilance or subordinated demeanor	Pre-Intervention Post-Intervention	2.37 4.06	1.368 1.342	-1.690	.002
Discrepancy between the history and clinical presentation	Pre-Intervention Post-Intervention	2.24 4.24	1.297 1.493	-2.000	.000
Several somatic symptoms arising from stress	Pre-Intervention Post-Intervention	2.30 4.35	1.716 1.195	-2.053	.000

Secondary Outcomes

One month after implementation of the human trafficking response protocol, 94% (n=16) of participants reported that there was a protocol for dealing with human trafficking in place at their clinic with 17.6% (n=3) reporting that the protocol was widely used (Table 3).

Table 3

Summary of responses to question 26: Is there a protocol for dealing with human trafficking in place at your clinic?

Response	Frequency (%)
Unsure	0 (0)
No	1 (5.9)
Yes, but not used	3 (17.6)
Yes, and used to some extent	10 (58.8)
Yes, and widely used	3 (17.6)

One month after implementation of the Human Trafficking Response Protocol, 82.4% (n=14) of participants reported that they had adequate human trafficking referral resources for patients at their clinic (Table 4).

Table 4

Summary of responses to question 27: Do you feel that you have adequate human trafficking referral resources for your patients at your clinic?

Response	Frequency (%)
Unsure	1 (5.9)
No	2 (11.8)
Yes	14 (82.4)

Discussion

In recent years, several professional organizations have issued position statements recommending that reproductive healthcare providers play an active role in identifying, assessing, and responding to victims of human trafficking in the clinical setting. These organizations include the American College of Obstetricians and Gynecologists (2011), Nurse Practitioners in Women's Health (2017), and the Association of Women's Health, Obstetric, and Neonatal Nurses (2016). National organizations such as the American Medical Association (2015), the American Medical Women's Association (Leonard Harrison et al., 2014), and the American Public Health Association (2015) have also made specific recommendations. Despite these efforts to provide guidance to healthcare providers, clinicians continue to feel unprepared to identify or correctly treat a victim. Effective interventions to promote clinician preparedness and increase clinician screening behaviors are needed. In this project, providing clinicians with an organization-specific human trafficking response protocol significantly improved clinician preparedness and significantly increased the frequency that clinicians asked patients additional screening questions when a warning sign of human trafficking was present. These findings are

consistent with other researchers who found that an education and treatment algorithm was an effective strategy to improve recognition and rescue of human trafficking victims (Egyud et al., 2017).

Prior work has suggested that barriers to incorporating screening and intervention into practice include lack of human trafficking knowledge or training (Chisholm-Straker et al., 2012; Ross et al., 2015; Recknor et al., 2017). In this study, clinicians reported an average of 4.98 (SD 6.62) hours of previous training on human trafficking. However, despite this previous training, self-reports of preparedness to identify, assess, and respond to victims of human trafficking were low. Pre-intervention, only 21.7% of respondents felt fairly or quite well prepared to identify human trafficking indicators based on patient history and physical examination and only 8.6% felt fairly or quite well prepared to ask appropriate questions about human trafficking and to appropriately respond to disclosures of human trafficking. Additionally, no respondents reported feeling fairly well or quite well prepared to make an appropriate referral for a victim of human trafficking. The frequency of screening for human trafficking was also low in the pre-intervention timeframe. Across the common eight warning signs included on the pre-intervention survey, from 17.7% to 34.8% of respondents reported that they never asked about the possibility of human trafficking when a patient displayed one of the specific warning signs. These findings indicate that even though healthcare professionals are receiving training about human trafficking, they still do not feel prepared to complete the important interventions necessary to screen or respond to victims and are not asking about human trafficking even when a warning sign is present. Therefore, healthcare organizations must provide further guidance to clinicians to promote the safe and appropriate identification and referral of trafficked persons

encountered in the course of patient care. The information from this study suggests that a human trafficking response protocol can be an effective tool for providing this guidance.

Although the two primary project objectives were met, opportunities for further improvement in processes surrounding human trafficking in the healthcare organization were identified as the secondary project objectives were not achieved. First, following the intervention, only 17.6% of respondents reported that the protocol was widely used in the clinic with a 90% benchmark. Given that only 35% (17/49) of clinicians employed by the healthcare organization completed participation in the entire project, it was expected that perception of use would yield a low rate. Formalizing the human trafficking response protocol into the healthcare organization as a standard operating procedure, expanding use of the protocol to all clinic staff, making attendance at a protocol in-service or educational session mandatory, and including protocol education in new employee orientation are systems-level directives to assist embedding and integrating the processes surrounding human trafficking within the organization. In addition, incorporating human trafficking screening questions into all patient visits and adding the questions into the electronic medical record would prompt standardized assessment, promote accurate documentation, and allow for measurement of screening behavior via chart audit as opposed to self-report. Conducting audits and monitoring based on established performance measures or quality indicators would provide an opportunity to provide feedback to individual clinicians. Audit and feedback have been shown to enhance normalization of new clinical processes by promoting the NPT constructs of coherence, cognitive participation, collective action, and reflexive monitoring (Johnson & May, 2015). These proposed interventions will be further explored by the primary investigator in collaboration with the Clinical Practice Director to ensure that the protocol is sustained and normalized as routine practice in the organization.

Second, following protocol implementation, 82.4% of respondents reported that they had adequate human trafficking referral resources at their clinic with a 90% benchmark. One possible explanation for this finding is that clinicians may have felt that they lacked printed referral information to provide to identified or at-risk patients. While the laminated copies of the human trafficking response protocol specified three referral organizations and provided contact information (websites, emails, and phone numbers) for each organization, no separate printed information was provided to clinicians for distribution to identified or at-risk patients. Importantly, inadequate community resources for which to refer victims and clinician lack of knowledge of extant resources have been previously cited as factors inhibiting victim identification (Recknor et al., 2017). Therefore, it is suggested that human trafficking referral organization contact information be added to the standardized patient resources brochure that is currently distributed to all clinics in the healthcare organization.

Limitations

There are several factors that should be considered in the interpretation of these findings. This project involved a small, homogenous, convenience sample of clinicians from a single reproductive healthcare organization which could affect generalizability to other groups or healthcare settings. The one group, pre-test post-test design provided weak support for causal inference as it was vulnerable to many internal validity threats. Therefore, without a comparison group, the investigator was unable to confirm if any impact on clinician preparedness or practice during the short timeframe of the project was due to attendance at the webinar and implementation of the human trafficking response protocol or other factors. Additionally, the clinicians who completed the surveys and attended the educational webinar introducing the protocol may have been more interested in human trafficking than clinicians who did not

participate, and thus provided more positive responses. Importantly, the data for this project were collected using an instrument that had not been tested for reliability or validity. Finally, clinician responses and behaviors were reported rather than observed and self-report response-bias could have been a factor by favoring better ratings.

Future Directions and Implications

There is currently a dearth of research examining the impact of human trafficking protocols on clinical practice with only two previous studies located in the literature (Egyud et al., 2017; Stoklosa et al., 2016). Therefore, this project contributes valuable information to the development of this knowledge base. However, this project was conducted at just one reproductive healthcare organization over a one-month time frame and did not explore the experience or satisfaction of clinicians using the protocol . Therefore, further quantitative and qualitative outcomes research on the relationship between human trafficking protocols, clinician screening practices, and clinician satisfaction using the protocol should be conducted. Ideally, future research should also explore use of the protocol and its impact on victim identification and referral in larger and more varied healthcare provider samples and practice settings over a longer period of follow up. The protocol framework used in this project could be easily replicated for use in additional reproductive healthcare affiliates within the study organization or in larger primary care, pediatric, or urgent care clinics by customizing the internal processes and external resources. Further evaluation of the impact of a human trafficking response protocol on clinician preparedness and screening practices in diverse healthcare settings and provider populations has the potential to assist researchers in better understanding facilitators and barriers to protocol use as well as establishing and validating ideal protocol content for general application.

Additionally, the findings from this project could be used to encourage the incorporation of human trafficking education and training into undergraduate and graduate nursing curricula. Key knowledge and skill deficiencies identified by the pre-intervention survey suggest that current education and training is insufficient and provides important insight into the learning needs of future Advanced Practice Nurses (APNs). The American Association of Colleges of Nursing (AACN) recommends that curricula contain opportunities for all students to gain information and clinical experience regarding domestic violence (AACN, 1999). Content on human trafficking could be easily integrated within these current curricula. The human trafficking response protocol is structured as an algorithm similar to many other medical decision-making tools, which facilitates its application in the educational setting (Bespalova et al., 2016). Utilizing an evidence based human trafficking protocol as a teaching tool could improve human trafficking knowledge and clinical skills in nursing students, and study of the intervention in this population is warranted.

Given the impact of human trafficking on public health and safety, future legislative and policy initiatives that increase funding for research on the best methods of victim identification, including protocol testing, should be proposed. Information from this project suggests that a human trafficking response protocol improves clinician knowledge and skills and may result in better identification and referral of victims. Therefore, further exploration to develop, refine, and disseminate evidence-based protocols to healthcare systems should be a priority area for future intervention. Additionally, policies that mandate healthcare organizations to have a human trafficking protocol in place should be considered by state legislatures and accrediting bodies. Finally, the AACN should specifically recommend the inclusion of human trafficking education into undergraduate and graduate nursing curricula.

APNs serve a vital role in the comprehensive care of persons presenting for care in outpatient clinical settings and are likely to have contact with a victim of human trafficking. This positive evaluation of a human trafficking response protocol has important implications for improving patient care. Better screening, assessment, and response to victims of human trafficking are key to interrupting the human trafficking cycle and promoting improved psychosocial and physical health outcomes in this vulnerable population. DNP-prepared APNs are in an ideal position to lead the effort to implement these tools. By advocating for policies that support human trafficking research and training and guiding the development and implementation of these interdisciplinary, evidence-based response protocols within their personal practices, healthcare systems, and educational institutions, DNP-prepared APNs can champion the effort to interrupt the human trafficking cycle and to combat this human rights travesty.

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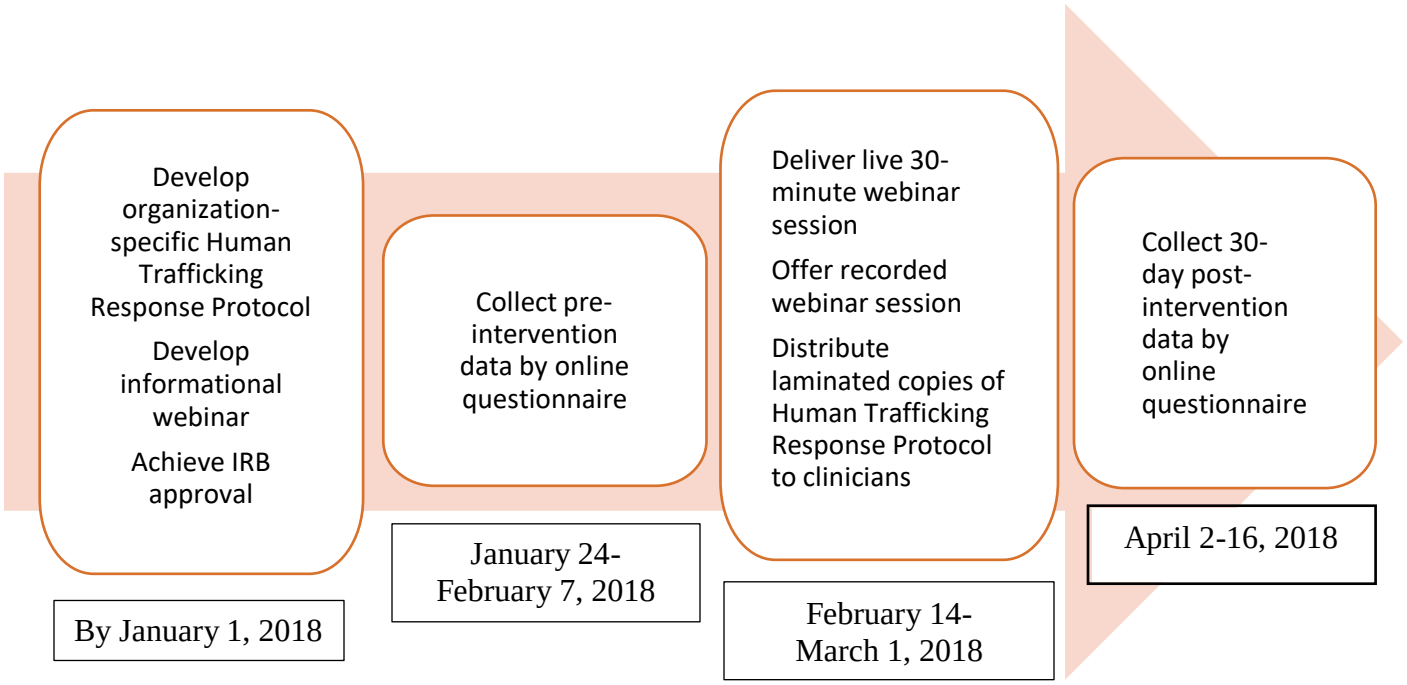
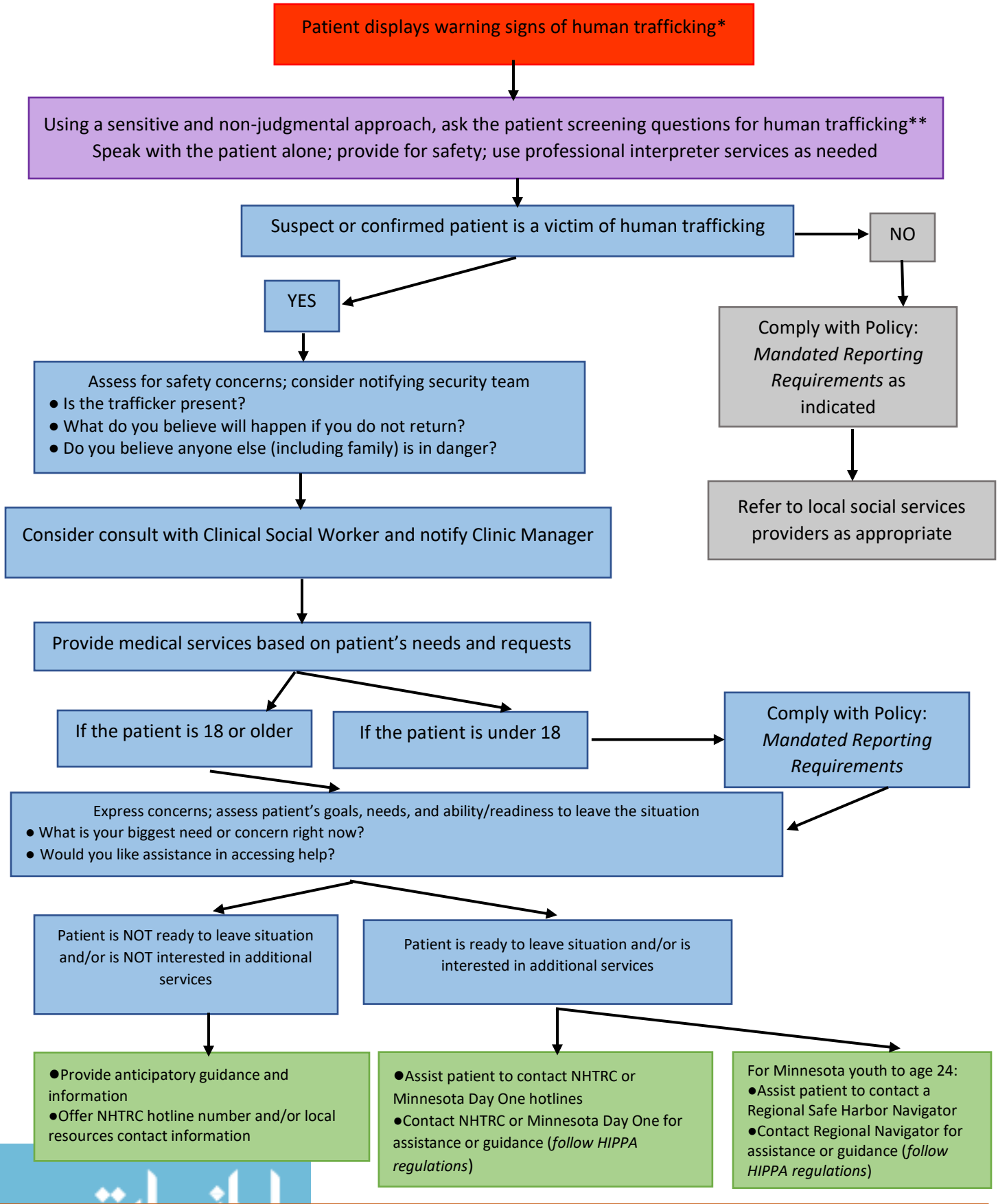
Appendix A

Timetable for Project Implementation



Appendix B. Human Trafficking Response Protocol



WARNING SIGNS OF HUMAN TRAFFICKING*

Behavioral Indicators

- Shares an inconsistent or scripted history
- Discrepancy between the history and clinical presentation
- Demeanor is anxious, submissive, tense, or nervous
- Patient recently arrived from somewhere else or claims to be “just visiting”
- Is resistant to assistance or demonstrates hostile behavior

Physical Indicators

- Signs of physical/sexual abuse, trauma, physical restraint, or torture
- Signs of malnutrition or dehydration; multiple somatic symptoms
- Has tattoos or other forms of “branding” that indicate ownership
- Multiple or repeated sexually transmitted infections or high numbers of sexual partners
- Multiple pregnancies/abortions

Control Indicators

- Accompanied by a person that does not let them speak for themselves
- Frequently receives texts or phone calls during the visit
- Is not in control of their identification documents and/or money
- Owes a debt to someone
- Exhibits fear and/or avoids eye contact

SCREEENING QUESTIONS**

- What type of work do you do?
- Does anyone take all or part of the money you earn?
- Do you ever feel scared or unsafe when you are working?
- Can you leave your job or situation if you want?
- Is anyone pressuring or forcing you to do anything that you do not want to do?
- Have you or your family ever been threatened?
- Where do you sleep and eat?
- Does anyone prevent you from contacting your family or friends even when you aren’t working?
- Has anyone ever held your ID or other legal documents without your permission?
- Have you ever received anything of value, such as money, a place to stay, food, clothing, or gifts in exchange for your performing a sexual activity?

HUMAN TRAFFICKING RESOURCE LIST

The National Human Trafficking Resource Center (NHRTC)

Helps trafficked individuals access direct services. Assists with safety planning, emotional support, and connections to emergency services. Provides guidance and technical assistance to health care professionals.

Hotline: 1.888.373.7888
Text: BEFREE (233733)

Minnesota Day One

Provides services to all victims of domestic violence, sexual assault, or sexual trafficking.

Crisis Hotline: 1.866.223.1111
Text: 612.399.9995

Minnesota Department of Health

The Safe Harbor system includes a statewide network of victim-centered, trauma-informed services and safe housing, as well as 10 Regional Navigators who are responsible for connecting youth (up to age 24) with services and serving as experts for their communities. Regional Navigators and service providers can be found at:

http://www.health.state.mn.us/injury/topic/safeharbor/docs/MDHSafeHarborReferral.pdf

Appendix C

Pre-Assessment Survey

BACKGROUND QUESTIONS:

1. To which gender do you most identify?

Male
Female
Transgender male
Transgender female
Gender variant/non-conforming
Prefer to self-describe:
Prefer not to answer

2. What is your age?

18-24
25-34
35-44
45-54
55-64
65-74
75 or older
Prefer not to answer

3. Which race/ethnicity best describes you?

American Indian or Alaskan Native
Asian/Pacific Islander
Black or African American
Hispanic/Latino
White/Caucasian
Mixed/Multiple ethnic groups
Prefer to self-describe:
Prefer not to answer

4. What is your specialty certification?

Women's Health Care Nurse Practitioner (WHNP)
Certified Nurse Midwife (CNM)
Family Nurse Practitioner (FNP)
Adult/Gerontological Nurse Practitioner (AGNP)
Physician Assistant (PA)

5. About how long have you been practicing as a Nurse Practitioner, Certified Nurse Midwife or Physician Assistant?

Years_____ Months_____

6. About how long have you been employed by the healthcare organization?

Years _____ Months _____

7. Approximately how much training on the topic of human trafficking have you received?

Hours _____

INSTRUCTIONS:

For the next 10 questions, please choose the response that best describes how prepared you feel to perform the following:

1. Ask patients appropriate questions about human trafficking

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

2. Appropriately respond to disclosures of human trafficking

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

3. Identify indicators of human trafficking based on patient history and physical examination

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

4. Assess a human trafficking victim's readiness to change

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

5. Utilize a trauma-informed approach when interacting with human trafficking victims

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

6. Help a human trafficking victim create a safety plan

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

7. Document human trafficking history and physical exam finding in patient's electronic health record

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

8. Make an appropriate referral for a victim of human trafficking

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

9. Fulfill state reporting requirements for human trafficking

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

For the next 8 questions, please choose the response that best describes how often in the past 30 days you have asked about the possibility of human trafficking when seeing patients with the following conditions:

10. High number of sexual partners

never seldom sometime nearly always always N/A

11. Multiple pregnancies or abortions

never seldom sometime nearly always always N/A

12. Inconsistent or scripted history

never seldom sometime nearly always always N/A

13. Accompanied by a controlling person

never seldom sometime nearly always always N/A

14. Multiple sexually transmitted infections

never seldom sometime nearly always always N/A

15. Hypervigilance or subordinate demeanor

never seldom sometime nearly always always N/A

16. Discrepancy between the history and clinical presentation

never seldom sometime nearly always always N/A

17. Several somatic symptoms arising from stress

never seldom sometime nearly always always N/A

18. Is there a protocol for dealing with human trafficking at your clinic/practice?

Unsure
No
Yes, but not used
Yes, and used to some extent
Yes, and widely used

19. Do you feel that you have adequate human trafficking referral resources for your patients at your clinic/practice?

Unsure
No
Yes

Appendix D

Post-Assessment Survey

INSTRUCTIONS:

For the next 10 questions, please choose the response that best describes how prepared you feel to perform the following:

1. Ask patients appropriate questions about human trafficking

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

2. Appropriately respond to disclosures of human trafficking

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

3. Identify indicators of human trafficking based on patient history and physical examination

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

4. Assess a human trafficking victim's readiness to change

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

5. Utilize a trauma-informed approach when interacting with human trafficking victims

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

6. Help a human trafficking victim create a safety plan

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

7. Document human trafficking history and physical exam finding in patient's electronic health record

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

8. Make an appropriate referral for a victim of human trafficking

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

9. Fulfill state reporting requirements for human trafficking

not prepared	minimally prepared	slightly prepared	moderately prepared	fairly well prepared	well prepared	quite well prepared

For the next 8 questions, please choose the response that best describes how often in the past 30 days you have asked about the possibility of human trafficking when seeing patients with the following conditions:

10. High number of sexual partners

never seldom sometime nearly always always N/A

11. Multiple pregnancies or abortions

never seldom sometime nearly always always N/A

12. Inconsistent or scripted history

never seldom sometime nearly always always N/A

13. Accompanied by a controlling person

never seldom sometime nearly always always N/A

14. Multiple sexually transmitted infections

never seldom sometime nearly always always N/A

15. Hypervigilance or subordinate demeanor

never seldom sometime nearly always always N/A

16. Discrepancy between the history and clinical presentation

never seldom sometime nearly always always N/A

17. Several somatic symptoms arising from stress

never seldom sometime nearly always always N/A

18. Is there a protocol for dealing with human trafficking at your clinic/practice?

Unsure
No
Yes, but not used
Yes, and used to some extent
Yes, and widely used

19. Do you feel that you have adequate human trafficking referral resources for your patients at your clinic/practice?

Unsure
No
Yes

20. Did you attend the webinar that introduced and explained the human trafficking response protocol?

Yes
No

21. Did you complete the online pre-assessment human trafficking survey before attending educational webinar?

Yes
No

Appendix E

Informed Consent Statement

UNIVERSITY OF NORTH DAKOTA

Institutional Review Board

Informed Consent Statement

Title of Project: Implementation of a Human Trafficking Protocol in a Reproductive Health Care Setting: The Impact on Clinician Preparedness

Principal Investigator: Gina Liverseed, MSN, RN, WHNP-BC
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Advisor: Dr. Brian Higgerson, DNSc, RN, FNP-BC, CNE
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PURPOSE OF THE STUDY:
You are invited to participate in a research study examining clinician preparedness and practices surrounding the identification, assessment, and response to victims of human trafficking because you are a clinician at Planned Parenthood Minnesota, North Dakota, South Dakota. The purpose of this DNP scholarly project is to evaluate the impact of implementing a Human Trafficking Response Protocol on clinician preparedness to identify, assess, and respond to victims of human trafficking.

PROCEDURES TO BE FOLLOWED:
Participation in this DNP project will include the completion of a pre-assessment survey, attendance at an educational webinar, and the completion of a post-assessment survey.

A web-link to a computer-based pre-assessment survey will be e-mailed to every clinician at Planned Parenthood Minnesota, North Dakota, South Dakota. In the pre-assessment survey, you will be asked to complete 27 questions. Questions in this survey are related to your educational preparation, years of experience, clinical practices surrounding human trafficking, and your self-perceived level of preparation for identifying, assessing, and responding to victims of human trafficking. The pre-assessment survey should take approximately 10 minutes to complete. **Completion of the pre-assessment survey will serve as your informed consent to participate in this DNP project.**

Approximately two weeks after completing the pre-assessment survey, you will be asked to participate in a 30-minute educational webinar. The educational webinar will introduce the use of the Human Trafficking Response Protocol that will be implemented at Planned Parenthood Minnesota, North Dakota, South Dakota. An educational webinar notification will be emailed to every clinician at Planned Parenthood Minnesota, North Dakota, South Dakota. The educational webinar notification will include webinar log-in information as well as the time and dates of two educational webinar offerings. You may elect to attend either one of the educational webinars as the content presented in the two educational webinars will be the same.

Approximately 30 days after the educational webinar, a web-link to a computer-based post-assessment survey will be emailed to every clinician at Planned Parenthood Minnesota, North Dakota, South Dakota. In the post-assessment survey, you will be asked to complete 22 questions. Questions in the post-assessment survey are related to your clinical practices surrounding human trafficking and your self-perceived level of preparation for identifying, assessing, and responding to victims of human trafficking. The post-assessment survey should take approximately 5 minutes to complete.

RISKS:
There are minimal risks of participating in this research and any risks are not beyond those experienced in everyday life.

BENEFITS:
The benefit of participating in this study is the opportunity to receive clinically relevant information about human trafficking. Furthermore, the information collected from this study might provide a better understanding of how clinicians provide care to victims of human trafficking.

DURATION:
The total participation time in this DNP project is approximately 45 minutes over a two-month time frame.

STATEMENT OF CONFIDENTIALITY:
The survey does not ask for any information that would identify who the responses belong to. Therefore, your responses are recorded anonymously. If this research is published, no information that would identify you will be included since your name is in no way linked to your responses.

All survey responses that we receive will be treated confidentially. However, given that the surveys can be completed from any computer (e.g., personal, work, school), we are unable to guarantee the security of the computer on which you choose to enter your responses. As a participant in our study, we want you to be aware that certain "key logging" software programs exist that can be used to track or capture data that you enter and/or websites that you visit.

RIGHT TO ASK QUESTIONS:
The principal investigator conducting this study is Gina Liverseed. You may ask any questions that you have now by contacting the researcher by email or by phone using the above listed contact information. If you later have additional questions, concerns, or complaints about the research please contact the project advisor, Dr. Brian Higgerson, at 701-777-4555 during the day.

If you have questions regarding your rights as a research subject, you may contact The University of North Dakota Institutional Review Board at (701) 777-4279. You may also call this number with problems, complaints, or concerns about the research. Please call this number if you cannot reach research staff, or you wish to talk with someone who is an informed individual who is independent of the research team.

General information about being a research subject can be found on the Institutional Review Board website "Information for Research Participants" http://und.edu/research/resources/human-subjects/research-participants.cfm

COMPENSATION:
You will not receive compensation for your participation.

VOLUNTARTY PARTICIPATION:
You do not have to participate in this research. You can stop your participation at any time. You may refuse to participate or choose to discontinue participation at any time without losing any benefits to which you are otherwise entitled. There are no threats or repercussions to your employment, should you choose not to participate in this project or complete the surveys.

You must be 18 years of age older to consent to participate in this research study.

Submission of the pre-assessment survey implies that you have read the information in this form and consent to participate in the project.