H.E.A.T. Institute - HEAL Trafficking - Levitt Center

Human Trafficking Response Protocols

Health Systems Pilot Project

Alameda County, California

Final Status Report
June 30, 2019

Report Prepared and Submitted by Susie Baldwin, MD, MPH
President, Board of Directors
HEAL Trafficking

ACKNOWLEDGMENTS

HEAL Trafficking is grateful to District Attorney Nancy E. O'Malley and Carla Dartis, Senior Strategist and Coordinator of the H.E.A.T. Institute, for recognizing the importance of the health care response in addressing human trafficking in our communities, and for spearheading this innovative pilot project. We are also grateful to the talented, dedicated professionals from Highland Hospital, Kaiser Permanente Medical Group and Oakland Medical Center, Sutter Alta Bates Summit Medical Center, and UCSF Benioff Children's Hospital Oakland who devoted their time and energy, on top of all of their other responsibilities, to advance the difficult work of transforming their systems to better support survivors of human trafficking.

Thank you to Kaiser Permanente Community Health of Northern California and the United Lutheran Church of Oakland, who along with the H.E.A.T. Institute, provided generous financial support for this project.

Finally, we extend our gratitude to Rafael Bautista and Sarai Smith-Mazariegos, with her team at Survivors Healing Advising and Dedicated to Empowerment (S.H.A.D.E), for reviewing this report and sharing their expertise.

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Health Systems Human Trafficking Response Protocols Pilot Project in Alameda County-- FINAL STATUS REPORT

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Accompanying this final report is a separate Appendix containing the internal human trafficking response protocols developed for UCSF Benioff Children's Hospital of Oakland, Highland Hospital and Kaiser Permanente Medical Center.

Introduction of Organizational Partners of the Pilot Project

The Human Exploitation and Trafficking Institute is the brain-child of Alameda County District Attorney Nancy E. O'Malley. The H.E.A.T. Institute was created to allow Californians to come together and review, rethink, reframe, and redesign how the state responds to human trafficking, with the recognition that there is a critical need to align systems and programs, and create critical infrastructure that provides and funds a comprehensive system of prevention and intervention.

As a result of being awarded the 2015 James Irvine Foundation Leadership Award for her ground- breaking work in combatting human trafficking, particularly the Commercial Sexual Exploitation of Children (CSEC), D. A. O'Malley invested the financial proceeds to create and sustain the Institute through its initial phases of identifying promising practices to strengthen California's infrastructure of prevention and response. H.E.A.T. employs a full-time coordinator, Carla Dartis, whose tireless work to improve Alameda County's and California's anti-trafficking response has advanced H.E.A.T.'s work with myriad stakeholders throughout the state.

In 2015, District Attorney O'Malley, working with former State Attorney General Kamala Harris, Chief Justice Tani Cantil-Sakauye of the Supreme Court of California, former State Superintendent of Public Schools Tom Torlakson, and Secretary of the California Health and Human Services Agency Diana S. Dooley, empaneled a 21-person highly diverse Blue Ribbon Commission of leaders to learn about responses to human trafficking in California, particularly for commercially sexually exploited children (CSEC). Through spring 2016, the H.E.A.T. Institute brought together over 1,200 stakeholders from multiple disciplines including survivors, purchasers, direct service providers, schools, health care providers, community based groups including faith-based organizations, law enforcement and child welfare agencies to share and learn the state of current responses in summits convened in all eight regions of California. The Commission received over 400 in-person and written testimonies from the attending stakeholders. That process culminated in the development of trauma-informed protocols and resources for law enforcement agencies, and led to the recognition that to address human trafficking, engagement of the health care systems is essential.

The H.E.A.T. Institute worked with Dr. Harrison Alter of the Andrew Levitt Center for Social Emergency Medicine at Highland Hospital, who was one of the Commissioners, to plan the Alameda County health care protocol pilot project, and engaged HEAL Trafficking to provide technical assistance.

LEVITT CENTER

The Andrew Levitt Center for Social Emergency Medicine is an independent nonprofit research and advocacy institute that explores the interplay of the emergency care system and social forces such as food insecurity, unstable housing, community and interpersonal violence and human exploitation. Together, these forces influence the health of our communities.

An estimated one-third of emergency department (ED) visits are for primary care, and patients often view the ED as a gateway to basic healthcare. Unfortunately, EDs in many areas of the nation are so crowded that they must regularly divert patients to other facilities, and the number of EDs nationally declines every year. The challenges of frequent ED use, racial disparities in pain management, and the scourge of hunger have motivated the Levitt Center to search for solutions in the discipline of emergency medicine and among ED stakeholders. In order to understand and address the challenges, ED researchers must expand their perspective on the nature of emergency care by recognizing the important and growing social role of the ED in the U.S. healthcare system and society.

The Levitt Center offers the notion of Social Emergency Medicine (SEM) as a framework for this expanded perspective. Through research and advocacy, they aim to expand the practice of emergency medicine to include social context in every encounter and to reach into all corners of the community to reduce the burden of acute illness.

Harrison Alter, MS, MD, who served on the H.E.A.T. Institute's Blue Ribbon Commission panel on the Commercial Sexual Exploitation of Children in California, is Founding Executive Director and Director of Research of the Levitt Center. He serves as Chair of the H.E.A.T. Institute's Health Committee and, with Carla Dartis and Dr. Susie Baldwin of HEAL Trafficking, planned the Regional Learning Exchange Meetings described in this report.

HEAL TRAFFICKING

We are a united group of multidisciplinary professionals dedicated to ending human trafficking and supporting its survivors, from a public health perspective. Please join our network and commit to healing human trafficking!

OUR VISION

A world healed of trafficking.

OUR MISSION

To mobilize a shift in the anti-trafficking paradigm toward approaches rooted in public health principles and trauma-informed care by

- Expanding the evidence base;
- Enhancing collaboration among multidisciplinary stakeholders;
- Educating the broader anti-trafficking, public health, and health care communities; and
- Advocating for policies and funding streams that enhance the public health response to trafficking and support survivors.

OUR GUIDING PRINCIPLES

- HEAL Trafficking engages in work that combats all forms of human trafficking;
- HEAL Trafficking supports trafficked people of all genders, ages, races/ethnicities, religions, origins, cultures, and sexual orientations;
- HEAL Trafficking believes all trafficked persons deserve access to a full range of health care including medical, mental/behavioral health, reproductive health, dental, and substance use disorder treatment services;
- HEAL Trafficking approaches human trafficking from a public health perspective that incorporates a socio-ecological framework and prevention strategies; and
- HEAL Trafficking promotes a survivor-centered, trauma-informed, evidence-based, practice-based approach to anti-trafficking efforts.

HEAL Trafficking Consultant Team

Lela Bachrach, MD, MS
Consultant for **UCSF Benioff Children's Hospital Oakland**

Dr. Lela Bachrach is a physician with the department of adolescent medicine at UCSF Benioff Children's Hospital Oakland (Children's), the designated first responder medical partner for Alameda County's commercially sexually exploited youth. She enjoys clinical work and precepting trainees at the main Children's Teen Clinic and affiliated school-based health centers. Dr. Bachrach is Co- Chair of the HEAL Trafficking Education & Training Committee. She leads Children's multidisciplinary professional group dedicated to ending human trafficking and supporting survivors from a trauma- informed, public health perspective. She is part of the faculty of the UC Berkeley-UCSF Joint Medical Program housed in the School of Public Health at UC Berkeley. She is also a mentor for students participating in the Children's Hospital Oakland Research Institute research programs. Her research and quality improvement projects include efforts to leverage technology, including electronic health records, to identify and assist individuals impacted by human trafficking. She is excited to work with the HEAL HEAT collaboration to improve the response to human trafficking at Alameda County health institutions.

Tonya Chaffee MD, MPH
Consultant for **Kaiser Permanente Medical Group (KPMG) and Oakland Medical Center**

Dr. Chaffee is a Clinical Professor of Pediatrics, at the University of California, San Francisco. She is Medical Director of the Child and Adolescent Support, Advocacy and Resource Center (CASARC) the referral center for children and adolescent who are alleged victims of sexual assault for the city and county of San Francisco. She also is the Director of Teen and Young Adult Health Center at San Francisco General Hospital where she provides primary care to teens and young adults including those who are victims of trafficking.

Dr. Chaffee completed her Pediatric Residency, Chief Residency, and fellowship training Adolescent Medicine at University of California, San Francisco. She subsequently completed an Academic Fellowship in Violence Prevention, at San Francisco General Hospital with a focus on youth violence. She subsequently earned a Master's in Public Health at UC Berkeley and has continued to conduct research and policy work the area of violence prevention. She has served on numerous local and national organizations focusing on youth violence, and most recently she served on the Institute of Medicine Committee's report on the Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States. She has been involved with several Bay Area initiatives and organizations working to address human trafficking.

Kimberly S.G. Chang, MD, MPH
Consultant for **Sutter Alta Bates Summit Medical Center**

Kimberly S.G. Chang, MD, MPH, is a Family Physician at Asian Health Services (AHS) in Oakland, California. In 2015, Dr. Chang completed the Commonwealth Fund Minority Health Policy Fellowship at Harvard, examining the role of federally qualified health centers in addressing human trafficking. Previously, Dr. Chang was the inaugural Clinic Director at AHS' Frank Kiang Medical Center, and provided care for many commercially sexually exploited children. She trained thousands of front-line multidisciplinary professionals on the human trafficking healthcare intersection, provided invited expert testimony to the US Helsinki Commission on "Best Practices in Rescuing Trafficking Victims", serves on the National Advisory Committee on the Sex Trafficking of Children and Youth in the United States, and co-founded HEAL Trafficking. In 2018, she was elected as the Vice Speaker of the House on the Executive Board of Directors for the National Association of Community Health Centers, and appointed to the American Public Health Association Committee on Women's Rights. She was nationally recognized with a Physician Advocacy Merit Award from the Institute on Medicine as a Profession, and featured in the New York Times, U.S. News and World Report, PBS Newshour, the Sacramento Bee, and several podcasts.

Dr. Chang received her BA from Columbia University, her MD from the University of Hawaii, specialized in family medicine at the University of California, San Francisco, and earned her MPH from the Harvard T.H. Chan School of Public Health, where she was awarded the Dr. Fang-Ching Sun Memorial Award for demonstrated commitment to promoting the health of vulnerable people.

Aisha Mays, MD
Consultant for **Highland Hospital**

Dr. Aisha Mays is a Family Physician who focuses on adolescent medicine. She is Medical Director of the Dream Youth Clinic in Oakland, California, faculty in the UC Berkeley/ UCSF Joint Medical program, and a clinical researcher at the UCSF Bixby Center Advancing New Standards in Reproductive Health. Dr. Mays' clinical work centers around youth who have been affected by commercial sexual exploitation (CSEC) and her research focuses on CSEC sexual health, reproductive autonomy, and reproductive justice. Dr. Mays trains medical professionals and students throughout the country on the medical community's role in supporting youth affected by CSEC. Dr. Mays is a member of the City of Oakland Interagency CSEC Steering Committee and a consultant with HEAL Trafficking.

Susie Baldwin, MD, MPH
HEAL Trafficking Project Coordinator

Susie Baldwin, MD, MPH is a Co-Founder of HEAL Trafficking and president of the Board of Directors. She is a preventive medicine physician who works as the Medical Director of the Office of Women's Health at the Los Angeles County Department of Public Health. Her career has focused on reproductive and sexual health, understanding and reducing health inequities, and on advancing public health solutions to human trafficking (HT).

Since 2005, Dr. Baldwin has supported survivors of HT through clinical care, training, advocacy and research. In partnership with the Coalition to Abolish Slavery and Trafficking and two community clinics, she provided specialized care for HT survivors in Los Angeles from 2005 – 2012. She was a member of the U.S. Department of Health and Human Services' Technical Working Group to develop the SOAR trafficking curriculum for health professionals in the U.S and the course director for the Planned Parenthood Federation of America's 5-module staff training on HT. She has been invited to submit testimony to Congress and in 2018 worked as an expert witness in Fresno County, California's first labor trafficking prosecution. In 2016, she was invited to give a TED MED talk on "diagnosing" human trafficking.

Dr. Baldwin graduated from Columbia University, received her Medical Degree from SUNY Downstate in Brooklyn, and attended the University of Arizona Zuckerman College of Public Health for her Master's in Public Health. She completed 2 research fellowships, in cancer prevention at the University of Arizona and in women's health services research at UCLA and the Veterans Administration. She has published many articles and book chapters and received numerous awards for her work.

Participating Hospitals

Highland Hospital is a 230 bed public county hospital in Oakland California. It opened in 1927 and is part of the Alameda Health System. It serves a patient population that is largely indigent, inner city, and diverse. Highland Hospital is known for being a major regional trauma center and teaching hospital.

Alta Bates Summit Medical Center is the East Bay's largest private, not-for-profit medical center and an affiliate of Sutter Health. Alta Bates Summit has been in service for over 100 years and they are a not-for-profit organization. They care for more low- income Medi-Cal patients in Northern California than any other health system.

Sutter Health
Alta Bates Summit
Medical Center

Founded in 1945, **Kaiser Permanente** is one of the nation's largest not-for-profit health plans, serving 12.2 million members, with headquarters in Oakland, California. From Kaiser Permanente's inception, the nonprofit organization has led with innovation, beginning with its prepaid health care services offered to Richmond shipyard workers during World War II. Today, the Richmond and Oakland Medical Centers are home to about 700 physicians and 5,600 employees who serve over a quarter of a million members yearly.

For over 100 years, **UCSF Benioff Children's Hospital Oakland (BCHO)** has been delivering exceptional medical care to children from all regions of California. Health professionals at BCHO cover over 30 pediatric specialties and care for tens of thousands of children annually. BCHO is a Level 1 Pediatric Trauma Center. The research enterprise is one of the top 10 NIH funded pediatric research centers in the country. BCHO is also a leader in examining social determinants of health and health equity.

UCSF Benioff Children's Hospitals

Hospital Based Champions and Protocol Development Teams

Summit Alta Bates Medical Center

Hospital Champions

First Phase – Rina Breakstone, MSW
Second Phase – ED clinicians, Dr. Shay Dedashtian, and Physician's Assistant Erika Ivans
Third Phase – Liz Collentine-Cole, MSW

The committee/team was represented by social workers, nursing management, ED clinicians (MD and PA), front-line nurses, and the corporate risk officer.

UCSF Benioff Children's Hospital Oakland

Hospital Champion: Dr. Lela Bachrach

Team Members

Adolescent Medicine
Dr. Celeste Allen, Dr. Gina DeAngelis, Dr. Jenifer Matthews, Dr. Tamita Robinson, et al.
Center for Child Protection
Dr. Jim Crawford, Kelsey Merl NP, Janelle Johnson MSW, Shelley Hamilton MSW, et al
Center for the Vulnerable Child
Elizabeth Jensen MSW
Mental Health
Shelly Nakaishi NP
Social Work
Martha Luster MSW
Emergency Department
Dr. Nisa Atigapromaj, Dr. Kat Osborne
Information Technology
Alvin Hendrix, Dr. Mike Lang, Anna Keller RD
Primary Care Pediatrics
Dr. Javay Ross, Dr. Celeste Allen
School-Based Health Centers
Saun-Toy Trotter and trainees
Nursing Education Staff
Reena Palacio, et al
Trainees
Dr. Nia Stallworth, Amy Kaur, Jerusalem Nerayo, Dr. Sam Cohen, Dr. Kara Harvil, et.al

Kaiser Permanente Medical Center Oakland

Hospital Champions

Emergency Department

Dr. Suzanne Lippert
Erica Smith Jacobs, RN
Rosie Boston, RN, MSN, Nurse Manager

Team Members

Emergency Department

Terrance Shaw, Nurse Manager
Julie Denison - RN, Assistant Manager

Department of Psychiatry

Pamela Orren, PhD, Licensed Clinical Psychologist
Miriam Rubel, LCSW, Child and Adolescent Psychiatry
Amy Orrechio, PhD, Licensed Child Psychologist
Karen Orsulak, LCSW, Child and Adolescent Psychiatry

Highland Hospital

Hospital Champions

Sexual Assault Response and Recovery Team (SARRT)
Kio Pak, MPA, ASW, SARRT Program Coordinator
Emergency Department and SARRT
Jennifer Collins, PA
Hillary Larkin, PA

Team Members

Emergency Department
Petrina Craine MD, ED Resident
Women's Health
Emily Tatel, NP
Department of Social Work
Helen Pagilagan, MS, DNP

Executive Summary

Studies from across the United States reveal that victims of human trafficking access health care services during their exploitation, creating valuable opportunities for education, empowerment, and intervention with this vulnerable population. The experience of labor or sex trafficking commonly results in physical and/or psychological harm, and victims are known to present to emergency departments, urgent care clinics, reproductive health clinics, labor and delivery units, community clinics and Federally Qualified Health Centers, dentists, pediatricians, public health centers, school-based health centers, private doctors' offices, and other settings. However, adult and child trafficking victims slip through these doors every day, undetected and unassisted, because health systems and personnel are not prepared to recognize and appropriately respond to this population. This lack of awareness and preparation ultimately prevents trafficked people from getting the help and care they need.

With hopes to address this critical gap in health care systems, HEAL Trafficking, in partnership with Hope for Justice, created the Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings. This Toolkit guides health care facilities through the process of creating the trauma-informed, patient-centered procedures and partnerships necessary for an appropriate response. The Toolkit encourages health care facilities to build upon and improve existing procedures for responding to patients who have survived intimate partner violence, sexual violence, and child abuse, while providing specific guidance for working with trafficked persons. The Toolkit outlines key protocol components and strategies, including the creation of linkages to service provision by diverse community-based, faith-based, and government agencies.

Recognizing the importance of engaging the health care sector in Alameda County's multisector response to human trafficking, District Attorney Nancy E. O'Malley and the H.E.A.T. Institute's Senior Strategist, Carla Dartis, engaged HEAL Trafficking to provide technical assistance for the development of human trafficking protocols for four hospitals in Alameda County, Highland Hospital, UC San Francisco Benioff Children's Hospital Oakland, Sutter Alta Bates-Summit Hospitals, and Kaiser Permanente Oakland Medical Center. These hospitals were selected to represent different kinds of operational hospital systems— a public hospital, a private nonprofit community based hospital, a hospital from one of the largest nonprofit health management organizations in the United States, and an academic children's hospital— to learn and evolve their practice together.

Expert HEAL Trafficking consultants, with the support of the H.E.A.T. Institute, worked with champions and teams from each participating hospital to review and amend hospital processes in order to better recognize and serve trafficked patients. Each hospital was assigned its own consultant. Carla Dartis also brought to the table many of the Bay Area's community-based agencies, to create a referral network through which health care providers can link trafficked patients who are ready to receive assistance. In addition, HEAL Trafficking worked with the H.E.A.T. Institute and the hospital champions to create a standardized response protocol for hospitals and health care agencies in Alameda County.

The project kicked off in May 2017 with a meeting of stakeholders from all the hospitals. This was followed by the initiation of a series of trainings, organized by the H.E.A.T. Institute, to ensure that hospital personnel were exposed to basic education about human trafficking and the delivery of trauma-informed care. In 2018, the process of protocol development and implementation accelerated. Designated protocol champions at each hospital organized teams that met periodically, with and without their HEAL consultants, to advance protocol development at each facility.

Under the direction of Dr. Harrison Alter of the Andrew Levitt Center for Social Emergency Medicine, in partnership with Dr. Susie Baldwin of HEAL Trafficking, hospital champions, team members, HEAL consultants, and community based service providers met with the H.E.A.T. Institute approximately quarterly for Regional Learning Exchange (RLE) Meetings. At RLE meetings, hospital teams discussed their progress in evaluating their existing processes and modifying them to create trauma informed protocols for responding to patients impacted by human trafficking. The group discussed challenges related to the child welfare response to youth trafficking, the utilization of electronic health records to share key information among hospital staff while also maintaining patient privacy and safety, and the lack of coordinated data collection and sharing around trafficking in the County. Hospital team members made connections with community based service providers and developed standardized referral forms. They discussed ways to deliver trauma informed care, new ICD-10 codes for documenting suspected or confirmed human trafficking, and best practices for use of imagery in human trafficking educational materials. The group worked together to refine the framework for a standardized Alameda County human trafficking response protocol that could be shared with all health care agencies in the County.

By the end of the project period, 3 of the 4 hospitals had developed human trafficking response protocols and flow charts to guide staff. These 3 hospitals plan to continue to improve their processes and to continue to come together for the Regional Learning Exchanges. The 4th hospital continues to encourage staff to learn about trafficking through materials shared by the H.E.A.T. Institute and online modules.

Goals for the project's future include the creation of formal quality assurance processes for the hospitals' protocol processes, improvements in data collection, the creation of collaborative data systems, involvement of hospital administration, a mechanism to deliver ongoing training, and the identification of funding sources to sustain this work. Dr. Lela Bachrach, the champion at UCSF Benioff Children's Hospital Oakland, has already been awarded a grant for her team's project, "Enhancing Our Response to Human Trafficking: A SafetyNet Mobilizing Support for Adolescents at Risk for Trafficking (SMART)," allowing Children's Hospital of Oakland to advance their innovative work.

This pilot project has achieved remarkable success in bringing diverse hospital teams and community agencies together to address human trafficking, and in advancing the creation of trauma informed response protocols to support patients impacted by human trafficking in Alameda County. Alameda County District Attorney, Nancy E. O'Malley, commented in December 2018 that the success of the project had far exceeded expectations. As the

Alameda County standardized protocol is shared, and more hospital and clinic staff learn about human trafficking and how to respond to it, valuable lessons will be learned that will inform health care providers in California and throughout the nation.

Dr. Hanni Stoklosa, Executive Director of HEAL Trafficking, stated her appreciation for Alameda County's comprehensive approach to human trafficking response. "We know that many trafficked people in the U.S. access health care while they are under the control of their exploiter. Yet most local anti-trafficking efforts do not include hospitals and health care providers, and most health care systems are not equipped to respond to patients who may be trafficked. This pilot project demonstrated that with leadership and dedicated effort, great progress can be made in developing trauma-informed, survivor-centered responses in different types of hospital systems, and in fostering collaboration between health care providers and essential partners in this work, including community based service providers."

"Having hospital human trafficking plans in place can make a true difference for trafficked people, and with the help of this incredible partnership, hospitals within Alameda County will develop the tools needed to bring light to human trafficking and to respond to it in an effective way," said District Attorney O'Malley.

HEAL Trafficking's
Policy Recommendations for Health System and Public Health Responses

In the H.E.A.T. Institute's funding proposal that led to the creation of the H.E.A.T. Institute – HEAL Trafficking Alameda Health Care Systems Protocol Pilot Project, it was noted that "While many local and regional organizations and collaboratives are engaging in this work, they are operating within their local areas often without connections to their counterparts in other regions of the state, and without channels to impact policy and practices at the state level." HEAL Trafficking has observed the same fragmentation of response efforts in California, with even neighboring Bay Area counties active in anti-trafficking work engaged in very different response processes for commercially sexually exploited children. The H.E.A.T. Institute provides an invaluable connection to state leaders and policy makers and can inform policy priorities throughout the state.

HEAL Trafficking's efforts to advise the H.E.A.T. Institute and Alameda County-based hospitals on development and implementation of response protocols for victims of human trafficking who present in health care settings have resulted in a set of policy recommendations for the H.E.A.T. Institute to consider for implementation in Alameda County and/or statewide.

1. Expansion of current California and county policies to address commercial sexual exploitation of children to victims of child labor exploitation and trafficking, as well as adults experiencing sex and labor trafficking.

    a. Funding for counties, similar to the Preventing and Addressing Child Trafficking program, to support other trafficked populations
    b. State-wide convenings for education and sharing of best practices
    c. Expansion of the California Department of Public Health's Safe and Active Communities branch to increase and coordinate public health efforts to prevent and respond to violence, including human trafficking, throughout the state.

2. Increased support for survivor recovery and rehabilitation services

    a. Case management, emergency response
        i. Grant funding to community based agencies to provide coordinated 24/7 response/bedside advocacy for both adult and minor victims, particularly in Counties where no such response is available
        ii. Guidance for CBO responders to partner with County and other agencies, including hospitals and clinics, through MOUs and streamlined referral processes
    b. Expanded programming and financing of housing support for survivors of violence, including human trafficking and intimate partner violence

3. Creation of systems of trauma informed care
   Despite the often-discussed concern among health care providers about how to screen patients for human trafficking, the environment in which patients are assessed is ultimately more important than the specific questions that are asked. The creation of patient-centered health care delivery systems that are trauma-informed, that is, which *adopt principles and practices that promote a culture of safety, empowerment, and healing,* are essential for optimizing the ability of such systems to respond to patients impacted by violence, including human trafficking. A *t*rauma-informed approach is defined by the Substance Abuse Mental Health Services Administration (SAMHSA) as a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.[1]

   a. Adopt a California-wide commitment to the provision of trauma informed service delivery. Other states, including Delaware and Alaska, and the federal government, have employed policy levers to address trauma experienced by children, adults, and communities, and to encourage the adoption of trauma-informed approaches to care.[2] While we do not recommend widespread collection of data on Adverse Child Experience (ACE) scores from individuals for clinical use, other strategies can expand the capacity of California hospitals, clinics, and other service providers to better understand trauma and advance resilience and recovery among diverse patients and clients.
   b. Create statewide CME and CEU opportunities for physicians and nurses to learn about the concepts involved in trauma-informed care.
   c. Engage health care systems leadership in the adoption of institution-wide trauma informed responses.
   d. Provide grant funding to Counties and/or health systems to implement these efforts.

4. Human Trafficking Education

   a. To create awareness among youth of labor exploitation and trafficking, incorporate "know your rights" curricula in youth education to parallel changes implemented with SB 1165, which amended the educational code created by the California Healthy Youth Act to incorporate sexual abuse and sex trafficking education.
   b. Promotion of health professional education, including awareness education on labor trafficking and sex trafficking of adults, with state-sponsored continuing medical education credits and quality assurance procedures to ensure that trainings are grounded in evidence and best practices, rather than ideological perspectives or specious content. A best practice is to train health professionals not just on trafficking, but on other forms of interpersonal violence including intimate partner violence, sexual violence,

child abuse, and elder abuse, to demonstrate their intersectionality and shared upstream determinants.

5. Streamlined and improved access to health care, inclusive of

    a. Protecting and expanding Family Planning, Access, Care, and Treatment (FPACT)
    b. Improving Medi-Cal coverage of and reimbursement for long acting reversible contraception, including Med-Cal Managed Care plans and immediate postpartum long acting reversible contraception
    c. Expanding delivery of mental health services to vulnerable populations with culturally appropriate service delivery
    d. Promotion of universal health care

6. Expanding support services to populations at risk for or impacted by human trafficking

    a. Increased resources for counties and social service agencies to serve women, men, transgender, and non-binary/gender-queer individuals of all ages involved in survival sex and commercial sex, outside of the criminal justice system
    b. Creation of job training and remedial education programs to serve incarcerated individuals, particularly those jailed for crimes related to prostitution and drug abuse, and individuals re-entering communities

7. Development of policies and programs to promote primary prevention of human trafficking

    a. Promotion of policies and regulations that protect vulnerable workers, including those not covered by federal protections (e.g. domestic workers and agricultural workers) and enforcement of laws prohibiting wage theft
    b. Investment in primary and secondary education, school nurses and counselors, parenting programs and supports including sick leave, and after school programs to ensure that all children receive the nurturing and wrap around services they need to remain safe and thrive.
    c. Remediation of deficiencies in county child welfare systems and increased support for youth aging out of foster care

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[1] Substance Abuse Mental Health Services Administration (SAMHSA) – Health Resources Services Administration (HRSA) Center for Integrated Health Solutions. Trauma. Available from https://www.integration.samhsa.gov/clinical-practice/trauma#trauma_informed_care. Accessed January 20, 2019.

[2] Shulman M. Policy Update: State and Federal Movement to Advance Trauma-Informed Care. Center for Health Care Strategies, Inc. November 15, 2018. Available from https://www.chcs.org/policy-update-state-and-federal-movement-to-advance-trauma-informed-care/. Accessed January 20, 2019.

Background and Overview of Project

Research has demonstrated that human trafficking victims in the United States access health care services, even while under the control of their exploiter.[1,2,3,4,5] However, trafficked patients are rarely recognized as such, in part because health care providers do not know how to identify them, and in part because myriad barriers prevent these patients from understanding or disclosing their status as victims. Even when trained about human trafficking, providers may be reluctant to assess patients for exploitation. As has been noted in the domestic violence literature, health care providers' lack of knowledge about how to engage with a person experiencing violence, their discomfort with the process of asking about experiences of violence, their lack of resources or unfamiliarity with resources to support a person who discloses they need help, and the amount of time it takes to appropriately respond to a patient who discloses violence all pose barriers to assessment of and intervention with patients whose health and safety may be in jeopardy.[5,6]

In the last decade, an increasing number of entities have developed educational trainings on human trafficking for health care providers, including the U.S. Department of Health and Human Services, Futures without Violence, Essential Access Health, the American Medical Women's Association, and Dignity Health. However, as Stoklosa, et al stated, "Training health care providers to recognize and respond appropriately to victims of human trafficking makes little sense unless the hospitals or other institutions in which they see patients has a set of procedures in place to guide decision making and action. Individual providers are unlikely to be able to safely intervene and provide help to human trafficking victims unless their efforts are coordinated with other members of the medical team, local victim resource organizations, law enforcement, and in many cases child-protection

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[1]Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in healthcare settings. Health and Human Rights. 2011;13(1):1-14. https://cdn2.sph.harvard.edu/wp-content/uploads/sites/125/2013/07/8-Baldwin.pdf. Accessed January 12, 2019.

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[3] Chisolm-Straker M, Baldwin S, Gaïgbé-Togbé B, Ndukwe N, Johnson PN, Richardson LD. Health care and human trafficking: We are seeing the unseen. J Health Care Poor Underserved. 2016;27:1220-1233.

[4] Family Violence Prevention Fund. Turning pain into power: Trafficking survivors' perspectives on early intervention strategies. San Francisco, CA. https://www.futureswithoutviolence.org/turning-pain-into-power-trafficking-survivors-perspectives-on-early-intervention-strategies/.Published October 2005. Accessed January 12, 2019.

[5] Beynon CE, Gutmanis IA, Tutty LM, Wathen CN, MacMillan HL. Why physicians and nurses ask (or don't) about partner violence: a qualitative analysis. *BMC Public Health*. 2012;12:473. Published 2012 Jun 21. doi:10.1186/1471-2458-12-473

[6] McGrath, M. E., Bettacchi, A. , Duffy, S. J., Peipert, J. F., Becker, B. M. and Angelo, L. S. Violence against women: Provider barriers to intervention in emergency departments. Academic Emergency Medicine. 1997; 4: 297-300.

services."[7] A trauma-informed response that prevents re-traumatization and respects patients' autonomy requires a shared understanding among medical staff and clear procedures for communication, maintaining patient privacy and safety, fulfilling mandatory reporting requirements, and managing patient flow. The multi-sector resources necessary to support trafficked people require advanced planning and relationship building with entities outside a given hospital, clinic, or doctors' office; integration of response with government agencies and community based organizations is essential. Human trafficking awareness training is therefore necessary but insufficient for developing survivor-centered response protocols.

RESPONSE PROTOCOLS TOOLKIT FOR HUMAN TRAFFICKING VICTIMS IN HEALTH CARE SETTINGS

In order to assist health care providers and systems with creating appropriate response protocols for trafficked patients, in 2017 HEAL Trafficking, in partnership with Hope for Justice, released its *Protocol Toolkit for Developing a Response to Human Trafficking in Health Care Settings*. The HEAL Toolkit serves to mobilize an interdisciplinary response to human trafficking that respects patient autonomy. It was developed by 17 experts around the country in medicine, nursing, social work, and law, and peer reviewed by eight others, including survivors and law enforcement. From its release in January 2017 through June 2019, the Toolkit was downloaded nearly 3,000 times, in all 50 states and 32 countries. An evaluation conducted among those who downloaded it during the first year it was available has found that 91% found it helpful or very helpful for the development, implementation, and improvement of health system protocols [preliminary data].

While ultimately the goal of implementation of anti-trafficking protocols at the local level is to enable the identification of victims of labor and sex trafficking so that they may be brought to safety, the goal of protocol implementation in health care settings is not to foster disclosure by trafficked persons. Rather, HEAL Trafficking aims to guide health care facilities through the process of creating safe procedures and spaces where professionals can provide exploited adults and minors not only the health services they need, but also education about their options and empowerment to seek assistance.

OVERVIEW OF THE PILOT PROJECT

In 2018, the H.E.A.T. Institute enlisted HEAL Trafficking to provide technical for development of a response protocol for hospitals and health care providers in Alameda County. This pilot project, funded by the James Irvine Foundation, grew out of the H.E.A.T. Institute's prior leadership of a Blue Ribbon Commission that was convened to understand

[7] Stoklosa H, Dawson MB, Williams-Oni F, Rothman EF. A review of health care institution protocols for the identification and treatment of victims of human trafficking. Journal of Human Trafficking. 2017;3(2):116-124.

and document ongoing efforts to address human trafficking in California. The Commission, chaired by Alameda County District Attorney Nancy O'Malley, held seven regional summits throughout the state in 2015-2016 to hear from local and regional representatives about their efforts, successes, and challenges. Approximately 1,200 people attended the regional summits, with 400 individuals providing verbal and/or written testimony to the commission. The summits included multiple survivor voices as well as multidisciplinary professionals in criminal justice, child welfare, social services, education, and medical and mental health care.

The H.E.A.T. Institute concluded from the findings of the Blue Ribbon panels and other research that *one of the most important levers of change to improve the outcomes of victims of human trafficking is access to a health care system and services that are able to effectively identify, respond to, and treat victimization.* The H.E.A.T. Institute collaborated with Dr. Harrison Alter of the Levitt Center for Social Emergency Medicine, one of the Blue Ribbon commissioners, and enlisted HEAL Trafficking's assistance with a pilot project to build and standardize the health care response to trafficking in the County. The H.E.A.T. Institute identified four diverse hospitals in Alameda County that were interested in participating in the project: Alta Bates Summit Medical Center, a private not for profit hospital; Highland Hospital, a public hospital in the Alameda Health System; Kaiser Permanente Oakland Medical Center, part of the largest health maintenance organization in the United States; and UCSF Benioff Children's Hospital of Oakland.

HEAL Trafficking's board president, Dr. Susie Baldwin, volunteered to oversee the technical assistance, and a HEAL Trafficking consultant was paired with each of the hospitals in order to provide ongoing technical assistance throughout the steps of the pilot project:

- Alta Bates – Summit Medical Center
  Kimberly S.G. Chang, MD, MPH
- Highland Hospital
  Aisha Mays, MD
- Kaiser Permanente Oakland Medical Center
  Tonya Chaffee, MD, MPH
- UCSF Benioff Children's Hospital
  Lela Bachrach, MD, MS

The H.E.A.T. Institute identified a hospital champion or two at each hospital, who were staff that would lead the process internally. These champions were tasked with engaging other hospital personnel in the process through the creation of teams or committees to work on the development and implementation of a human trafficking response protocol. Hospital teams initially focused on protocols for emergency medicine (Alta Bates, Kaiser Permanente Oakland), emergency medicine and women's health (Highland), and hospital wide (Children's).

Table 1 shows the timeline and steps of the pilot project, including meeting dates.

Table 1. Schedule of Core Project Organizing Meetings (excluding hospital protocol development work group sessions)

Protocol Kick Off Meetings:

Purposes: introduce hospital project and protocol toolkit, clarify current approaches, affirm commitment to organizational change, introduce HEAL Trafficking, Community Partners in East Bay, Hospital Champions and Internal Health Teams from each site.

Location	Date	Attendance	Notes
Kaiser Permanente Oakland Medical Center	July 31, 2017	32 attended	
Highland General Hospital	September 18, 2017	16 attended	
Alta Bates Sutter Ashby Campus	July 15, 2017	20 attended	transferred to Summit Campus effective April 18, 2018
UCSF Benioff Children's Hospital of Oakland	August 16, 2017	21 attended	

Regional Learning Exchange Meetings

Location	Date	Attendance	Time	Notes
Kick-Off for all 4 hospitals at Highland Hospital	May 23, 2017	36 attendees	9:00 am to 12 pm	
Progress Meeting at Oakland Family Justice Center	June 25, 2018	17 attendees	1:00 pm to 5 pm	
Progress Meeting at ACDO-CEPD office	October 22, 2018	22 attendees	1:00 pm to 5 pm	
Final Meeting for 2018 at ACDO-CEPD	December 4, 2018	19 attendees	9:00 am to 12 pm	

Outreach/Education

Location	Date	Attendance	Time	Notes
Alameda Contra Costa Medical Association Human Trafficking Summit	March 1, 2018	90 people trained	5 pm to 9 pm	Presenters: All Hospital Champions Teams, SHADE Project, HEAL Trafficking (Drs. Chang, Mays, Bachrach, Baldwin), Local Partners: Banteay Srei, Catholic Charities, Contra Costa Coalition, Asian Pacific Islander Legal Outreach, & Alameda County District Attorney Office. Co-Sponsored by HEAT Institute – CME credit offered training in identification, trauma-informed care and approaches to address human trafficking

The project kicked off with a meeting at Highland Hospital where personnel from the H.E.A.T. Institute, each of the four hospitals, all of the HEAL Trafficking consultants, representatives of community based and government agencies, and other key stakeholders and experts gathered to learn more about the plan. Subsequently, each of the other hospitals held a kick off meeting, bringing more staff from their institution to the table. Carla Dartis was instrumental in identifying community based agencies with capacity to provide shelter, social services, case management, and legal services to human trafficking survivors. She also engaged the Alameda County Department of Child and Family Services. Following kickoff meetings, the H.E.A.T. Institute coordinated and co-led with survivors basic training in human trafficking awareness and trauma-informed care at different hospital sites. These trainings were essential to provide a critical mass of staff at each institution who understood fundamental concepts necessary for protocol implementation.

The project included Regional Learning Exchange Meetings scheduled approximately quarterly throughout the year, where the full group would re-convene to discuss progress at each facility, address challenges faced, plan next steps, and share resources. One of the goals of the project was to use the Regional Learning Exchange meetings to develop a streamlined human trafficking response protocol for all health care providers in Alameda County, to guide interactions with patients potentially impacted by trafficking, and to link with community partners to provide services to these patients. A standardized protocol is important to expand the solutions identified or created by the H.E.A.T. pilot project to health systems in Alameda County that would be unwilling or unable to develop their own in-depth internal procedures. At the Regional Learning Exchange meetings, all team members provided feedback on the draft versions of the standardized Alameda County Human Trafficking Response Protocol so that the HEAL Trafficking team could revise and refine it. The resulting one-page standardized document can be used to guide hospitals and clinics throughout the region, and also has been customized for dissemination nationally by the American Hospital Association's Hospitals Against Violence campaign.

Hospital champions were expected to meet with their team on a monthly basis through the course of the one year project to progress with protocol development and implementation, with HEAL consultants attending some meetings and remaining in contact with the champions through email and phone calls. During the first few months of the project, each group of hospital champions and their teams were asked to collectively complete 3 worksheets developed by HEAL, including a needs assessment and a detailed examination of their current hospital practices as they related to the 10 recommended elements of a trafficking response protocol, as outlined in the HEAL Protocol Toolkit.

The process did not entirely unfold as planned, with scheduling and coordination challenges preventing routinization of hospital team meetings at some locations, and in planning for meetings that could include the HEAL consultants as advisors. However, when HEAL consultants were unable to attend hospital meetings, H.E.A.T. Institute staff often attended to facilitate planning and coordination with the hospital champions.

By mid-2018, the hospitals began using a design-build process to create their protocols, refine, and implement them. [Note: Because of changes in structure and leadership, this process did not advance at Alta Bates – Summit.] By December 2018, three of the four participating hospitals had developed protocols to respond to trafficking victims in their facilities, creating systems that could be further refined for improvement and deeper penetration within the individual hospitals. These hospitals also created accompanying flow charts for visualization of their protocols.

The H.E.A.T. Institute developed and shared with all the teams a comprehensive list of community-based service providers who served as referral sources, and many representatives of these agencies attended the hospital kick off and Regional Learning Exchange meetings. Relationships with community-based agencies were thereby fostered, with the development and sharing of standardized referral forms and processes.

FINAL STATUS REPORT

This report provides a summary of this project. It documents the impressions of HEAL consultants of their hospitals' strengths and weaknesses, and challenges and successes in moving toward protocol creation. It contains overall impressions of the project and lessons learned from the perspective of the H.E.A.T. Institute and HEAL Trafficking, as well as feedback from the hospital champions and teams, community partners, and human trafficking survivors. The report also includes HEAL's suggestions for statewide policies that could strengthen the role of the health sector in responding to human trafficking and expand the work of protocol development and community partnership statewide.

Assessment of Protocol Development at Alta Bates Sutter/Summit Medical Centers as Recorded by HEAL Trafficking Consultant

STRENGTHS

The team's strength was in overall engagement and interest on the front-line level. They were very invested in training and awareness building at the two campuses, and this enthusiasm continued. Individual provider and staff awareness increased and training occurred. The team was able to get community based resources, county resources, and federal/national resources— including materials from the National Human Trafficking Technical Assistance Center, the National Human Trafficking Hotline, and Futures Without Violence— into the individual awareness and practices of the clinicians and social workers/case managers. Copies of the H.E.A.T. Institute Resource binder were shared for placement at each emergency department site and nursing station. Team members discussed the need to designate a centralized location for the binder for when social workers/case management were not in the house after hours. The team was able to get awareness signage from different sources to hang in the waiting room and bathrooms, and began the process of getting these materials approved for display. The team located online training modules for use by individual staff. There was also at least one patient intervention during the course of the technical assistance period. The protocol team's efforts laid the groundwork for adoption of a county-wide protocol.

CHALLENGES

At the outset, the Sutter Alta Bates Summit Medical Center presented a complicated system for protocol development and implementation into the Emergency Departments (ED). Structurally, the system consisted of two different ED campuses in two different cities (Oakland for Summit Hospital, and Berkeley for Alta Bates Hospital); and two different business enterprises staffing the emergency department (the independent physicians/providers group, and the hospital/health system employed support staff of nursing, social work, case management, security, technicians).

Despite initial engagement, excitement and interest with the team and individual members, the toll of personnel turnover, and bureaucracy hurdles, coupled with lack of management support and buy-in led to waning interest and energy. Meetings were held only every 2 months; little protected time in between to get the actual "tasks" done meant that progress was slow. The frequent "lack of wins" – a block from a manager, colleague turnover – sapped the enthusiasm and energy of the team/champions. There was also poor morale at the institution, due to turnover in front-line staff, management, and executive level personnel.

The lack of protected time created barriers to a sustained initiative, with members entering and exiting the initiative at various stages – this led to stagnant and repetitive discussions. While Provider (MD/NP/PA) personnel have some protected time, the protocols needed to

be completed in parallel with nurses, social workers, and other hospital staff; the providers would not develop a human trafficking protocol without hospital side making or agreeing to same protocol/policy. There was tension between moving forward with taking action or waiting for administrative approvals, as the team was uncertain if administrative approvals were necessary to move forward.

There was diffuse hospital champion leadership with poor accountability for goals/objectives, and the lack of project management skills on the team (team consisted mostly of front-line clinicians: providers, nurses) created difficulty in moving the protocol development and implementation.

The administrative structure of the emergency room (ER)– with providers including NPs, PAs, and MDs working as part of an independent group/corporation, whereas nursing, social work, and case management are hospital employees – created duplicative protocol implementation and approval through two different administrative and bureaucratic structures. Furthermore, because there were two different EDs (Alta Bates Hospital in Berkeley and Summit Hospital in Oakland), there was inconsistent participation from team members when the meeting locations were at the other hospital.

RECOMMENDATIONS

The ABSMC protocol champion and team need guidance in navigating the hospital bureaucracy. Next steps should include the engagement of hospital leadership to ensure protected time or accountability of champion front-line staff to lead the initiative. Furthermore, there should be administrative staff to assist with project management, as this is not a strength of front-line clinical staff (who tend to be the champions of the issue). The ABSMC team needs assistance developing a project plan/timeline; currently the team is responding to singular tasks that come up during the meetings.

A county-wide protocol as presented to ABSMC may be easier to shepherd through the clinician's group and the corporate hospital entity – due to steps and responsibilities and resources laid out clearly for assignment to personnel. A system-wide ED campaign on Human Trafficking could be developed, to ensure that there is universal education about the issue amongst various personnel, and then a clear roll-out with time frame for a county-wide protocol. This will entail a project management administrative staff or possibly an internal consultant to assist the EDs with implementation.

Assessment of Protocol Development at Highland Hospital as Recorded by HEAL Trafficking Consultant

STRENGTHS

The Highland Hospital Human Trafficking Team consists of very strong, dedicated members, many of whom were working on human trafficking medical service provision and coordinated care delivery before the formation of this formalized protocol team. The team members brought with them significant institutional knowledge of the barriers and facilitators to health care service delivery for those affected by human trafficking at Highland Hospital.

A unique aspect of the Highland protocol team is that it primarily consists of personnel from the established and well known Highland Hospital Sexual Assault Response and Recovery Team (SARRT) team. The SARRT team provides beside advocacy, accompaniment, and case management to support Sexual Assault and Domestic Violence survivors in Oakland and out of county, and runs a 24/7 Rape Crisis Line. The protocol team has been able to adapt its existing protocols to create the human trafficking protocol, as patients who are impacted by sex trafficking may also experience sexual assault or domestic violence, and the provision of trauma informed care to patients experiencing these different forms of violence has many similarities. Additionally, members of the Highland Hospital team, including Dr. Harrison Alter, HEAT Institute's Blue Ribbon Commissioner and head of health care working group, and Physician Assistants Hillary Larkin and Jennifer Collins, participate on city and county-wide human trafficking roundtables. This includes the Alameda County SafetyNet roundtable, which was founded by Alameda County District Attorney's Office, making the team already aware of key human trafficking community partners and county-wide initiatives. These strengths, combined with the team's shared values of supporting patients, ideally positioned this team to create an effective human trafficking protocol to support Highland Hospital patients.

Throughout the year long process of protocol development, the Highland Hospital team had many successes. The team was able to pique the interest of several departments throughout the hospital including the Department of OBGYN / Midwifery and Medical Education, with representatives from those departments joining the team in protocol development. This helped to extend the effort outside of the emergency department and into the women's health (where patients had been previously identified as being affected) and also among the medical trainees to add to the foundations of their medical training. Additionally, the team champions, Kio Pak (coordinator of the Sexual Assault Crisis Center at Highland Hospital) and Jennifer Collins of the Emergency Department, created and

presented several Human Trafficking 101 trainings to the Highland Emergency department staff to provide staff and medical providers (PA's and MDs) with knowledge and shared understanding of the hospital's process to assess and support patients who may be affected by human trafficking. The protocol team also partnered with Carla Dartis, Senior Strategist of the Human Exploitation and Trafficking (HEAT) Institute, and Sarai Smith Mazariegos, Executive Director of the SHADE Project (Survivors, Healing, Advising and Dedicated to Empowerment) to provide a hospital-wide human trafficking training.

A major success for the Highland Hospital Protocol Team was the funding of a 24-hour sex trafficking bedside advocate through the SARRT program. The SARRT team collaborates with community-based organizations including Bay Area Women Against Rape (BAWAR) and Tri-Valley Haven to provide this service to any patient who presents to Highland who is suspected to be affected by or at-risk for sex trafficking. The bedside advocates provided a critical supportive resource to potential sex trafficking victims, serving as a liaison between health care providers, law enforcement, social services, etc. and the patients.

An added success for the Highland Hospital team was their ability to create a streamlined referral process for any medical provider seeing a patient who may be potentially at risk or affected by sex trafficking. (See flow-charts in the Protocol Flow Charts Section). Through hospital-wide trainings, all medical providers were instructed to contact the hospital social worker for any and all suspicions of sex trafficking, who then contacts the SARRT Team to provide bedside advocacy and accompaniment. The hospital social worker evaluates the patient with the SARRT Team and activates the human trafficking protocol if necessary. This streamlining and standardization took the pressure off of medical providers to be experts in human trafficking (sex trafficking, specifically) in order to refer patients for support and hopefully will lead to a lower threshold for patients receiving assessment and support.

An additional success was in the centralization of all sex trafficking cases, where cases are now housed and managed by the SARRT team. During the protocol development year, the SARRT team received grant funding to create a separate medical record system to house all SARRT cases, including sex trafficking cases, to only be viewed by hospital personnel working with these clients. This allowed the SARRT team and case managers to keep close track of all confirmed and suspected sex trafficking patients.

The SARRT department also received funding to provide temporary emergency housing for patients affected by sex trafficking including CSEC. They have been able to work with community housing programs to pay for emergency housing for these patients and are planning to fund two beds on reserve for Highland Hospital patients at the local youth shelter.

CHALLENGES

While the Highland Hospital team is very strong in sex trafficking and CSEC support and knowledge, they faced challenges in addressing labor trafficking. The hospital did not have pre-existing support for patients affected by or at-risk of labor trafficking prior to the protocol team development, and the funding that allowed the SARRT team to work with survivors of sex trafficking did not cover their work on labor trafficking. They did not incorporate in-depth labor trafficking into their trainings, and did not develop any procedures to address labor trafficking during the period of technical assistance. The Highland team does hope to improve policies in the near future by building upon knowledge gained from the Regional Learning Exchange meetings and the partnerships built during this time.

The Highland SARRT team utilizes a separate electronic health record (EHR) system from the hospital's EHR. This system provides a unique layer of confidentiality, allowing survivors of sexual assault, domestic violence, and sex trafficking to see medical providers without the fear of their information being accessible to a subpoena. This confidentiality allows patients who are vulnerable and at potential risk for legal repercussions to readily seek medical and mental health assistance. However, because only members of the SARRT team have access to the system, there are also disadvantages in having the separate EHR, in that it siloes information from other providers at the hospital who can view only a code or a note that indicates involvement of the SARRT team in the patient's case. The problem with using this system for trafficked patients is that their exposure to sexual assault and other harms may be ongoing, and if concerns about trafficking were flagged in the standard EHR, subsequent encounters with hospital staff in other departments, such as the Emergency Department or Obstetrics Gynecology, could result in the provision of additional resources and support to these patients. With the separate, protected EHR, the majority of the medical staff may not recognize that certain patients are affected by or at risk for sex trafficking and will not see notes from the SARRT team to alert them to previous hospital assessments or interventions. While there are clear benefits to keeping the SARRT team's records private, the withholding of certain key information from other hospital staff can cause both over and under evaluation of patients regarding sex trafficking. It also may cause staff to have decreased awareness about the prevalence of sex trafficking at Highland, making it more difficult to integrate the idea of human trafficking into their medical evaluations and assessments.

An additional weakness of the Highland Hospital protocol is that the protocol team decided to train medical providers only to call the social worker or SARRT team for suspected or verified sex trafficked patients. While the protocol team trains medical staff about common red flags and warning signs of sex trafficking, they advise hospital medical staff against further connecting with suspected or confirmed patients. The medical providers are

instructed to only to refer to social work or SARRT. The SARRT team's concern is that most medical providers do not have time or will not achieve the level of competency to provide adequate assessment or support for trafficked patients, and will ultimately do more harm than good. The SARRT team's goal is to minimize the re-traumatization of patients and to allow other teams to focus on the patients' medical needs, However, by centralizing their expertise, they may be placing their other colleagues— and the patients they care for— at a disadvantage. This is particularly true when patients' presentations at the hospital are unrelated to sexual assault or sexual health problems, and for survivors of labor trafficking. By not providing other hospital staff more comprehensive education on assessment and support for trafficked patients, they will not know how to truly care for these patients and may miss critical issues as a result.

The greatest challenge during this year of protocol development at Highland Hospital was scheduling time for the protocol team to meet. In the early months of protocol development, the team along with the HEAL consultant met monthly. After about three months, the hospital protocol team canceled future meetings. One of the protocol champions went out on medical leave and the other had a major change in her work schedule, making it difficult for her to attend meetings during the day. Without consistent meetings, the HEAL consultant was not able to support the Highland team in protocol development or identify potential gaps in process or development. The protocol team became fragmented, losing the Women's Health and resident participants. The protocol team was reduced to a core team of staff who had already been working on human trafficking, sexual assault, and domestic violence efforts. The team lacked fresh and new perspectives on how human trafficking victims present to Highland and best way to support them.

An associated challenge was with the HEAL consultant meeting with the hospital champions. The HEAL consultant made many repeated efforts over the protocol development year to meet with the hospital champions to troubleshoot challenges, check in on process, and provide support. Likely due to the aforementioned personal challenges, the hospital champions were rarely available to meet by phone on in-person. This left the HEAL consultant at a disadvantage on what the Highland team needed or how to support them.

RECOMMENDATIONS

The Highland Hospital team has produced a consummate guide how the hospital will assess and support patients affected by sex trafficking. They now need to expand this guide to include assessment and support for those affected by labor trafficking. The protocol team will need significant education and guidance around labor trafficking in order to do this. To better engage Highland colleagues from other departments in the process of human

trafficking protocol development/implementation, the SARRT team can consider finding partners from the ED, Women's Health, or other areas to lead work on the response to patients who are labor trafficked. Advocating for protected time for the hospital protocol team members is also essential to ensure that staff can meet regularly to work on protocol development, implementation, and refinement. In addition, including social work leadership as a part of the protocol team is essential because their department currently provides the 24 hour in-house support for sex trafficked patients.

The Highland Hospital protocol champions will also need to determine how they will provide real time support for labor trafficked patients, as they do with sex trafficked patients. Perhaps it will be helpful for their funder to know that labor trafficking survivors also commonly report sexual assault (for an overview, see http://www.ncdsv.org/images/GFC_OverlookedSexualViolenceInLaborTrafficking.pdf).

To better communicate with other Highland staff about the existence of trafficking among the patient population, the SARRT team can consider development of a specific code, like the 261/DV code for domestic violence, for inclusion in the standard EHR. or can utilize new ICD-10 codes for human trafficking.

Assessment of Protocol Development at Kaiser Permanente Medical Group (KPMG) and Oakland Medical Center as Recorded by HEAL Trafficking Consultant

SUCCESSES

KPMG includes a violence prevention component in their care delivery that contains well established policies and procedures for addressing certain forms of interpersonal violence that include, but are not limited to, child abuse and domestic violence. Because of the established internal organizational policies/procedures/protocols within KPMG that were addressing other forms of violence and abuse it became somewhat easy to incorporate this new human trafficking protocol within their existing violence prevention efforts. In addition, because the human trafficking protocol was implemented as another component of their violence prevention efforts, it provided for the capacity to address training needs across the organization, and also includes mechanisms for the protocol to be continually changed or modified as needed, including changes that may need to be made across different jurisdictions outside of Alameda County.

The participants who were represented by the Kaiser team also were in key stakeholder positions that could help facilitate making the needed changes within the hospital organization. Such changes included regional level participation (e.g. Electronic Medical Record changes) in order to ensure there was some standardization in how the protocol was being implemented as well as communicated with others across the health system. In addition, the KPMG staff were all very passionate about making the protocol work, and they were very flexible in adapting it to the KPMG current systems of care.

In addition, many of those who were part of the KPMG team were open to working with the various local Alameda county community-based organizations, who were an integral part of the human trafficking response. This could only be achieved by the KPMG team working closely with other local CBOs to develop a system of referrals as part of their internal human trafficking protocol.

Training of others in the health care team was also easily developed given the existing infrastructure for meeting the training needs of a wide variety of staff/employees within the KPMG model of care including within their violence prevention efforts.

The KPMG team was able to effectively develop a draft protocol that was implemented in a few departments within the hospital system. This included utilizing the standardized policy of rooming all patients alone in Emergency Department settings. After the protocol was implemented, the KPMG providers were beginning to track those identified HT patients and their responses for the appropriate internal and external referrals.

CHALLENGES

It was difficult to meet with KPMG staff to review what was in place and what needed help, given that they scheduled their regular meetings during the consultant's clinic time. However, they were able to independently develop and implement the protocol with limited needed technical assistance.

One overall challenge, that was not unique to the team at KMPG, was the fragmentation of the many various responding referring agencies (i.e. sex vs labor vs minor vs adult). As a result of not having a central identified agency that can provide a 24/7 response, many providers found it hard to know which agency performs what in responding to identified survivors/victims.

There were also some regional issues, such as the need to create new EMR templates, but these appear to be able to be worked out as the protocol was implemented.

There was also not a current means for quality improvement and/or case review to ensure that if issues arise within the Kaiser system as the protocol is developed and implemented, they would be addressed. However, given the current mechanisms for Quality Improvement and/or case review in the KP system, this appeared to be something that could easily be developed moving forward.

It was also noted that as the protocol was implemented, there was as yet no understanding of how ongoing training on human trafficking (HT) will occur given turnover of staff/clinicians within the various depts

What may be more challenging is how each hospital system can address some of the issues, including organizational issues, in the county-wide response to HT. This highlights the need for a regional HT protocol composed of separate hospital champions who can continue to meet and discuss issues/successes in protocol implementation and modifications at the local, county-wide level as issues and problems arise, and include those agencies identified as part of the community-based response.

RECOMMENDATIONS

As mentioned above, one of the more challenging aspects in responding to the needs of HT victims/survivors is their often unique and individual circumstances that are often based on their trafficking situation. Because many of the Alameda County human trafficking serving agencies cannot meet all the needs for survivors, and survivors often have different individual needs that often cannot be met by just one referring agency, the referring health care providers must currently refer patients to several various agencies to attempt to meet each individual's unique circumstances. In addition, it is beyond the scope of the health care providers' responsibility to ensure that a patient can access all the various outside

referring agencies that a particular patient may need based on their particular trafficking situation. Many of these needs could be met by having a simplified 24/7 coordinated case management response that is accessible to all hospital systems and that can ideally provide an appropriate and timely response.

Moving forward, there needs to be established means for providing ongoing monitoring or tracking of those victims/survivors who are identified within KPMG, along with the ability to provide ongoing feedback about the effectiveness of the protocols. This feedback needs to include how the protocols are performing not only within each health system, but also regionally as well. This could be achieved by hospital-wide case or peer review that can address system issues or identify where changes may need to be made to address issues as the come up. Similarly, such peer or case review could be implemented regionally, particularly if cases demonstrate issues that are outside the scope of the individual hospital system of care and represent issues at the county level. Another example might be to have a regional HT oversight committee that can address particular policies and/or procedures that are, or are not working at the regional level, and that can help facilitate the various hospital organizations in working together, making necessary changes to their individual HT protocols, or to the broader county-wide HT protocol. This can ensure that all participating hospital organizations and the various county-wide HT serving agencies are effectively working together to address the needs of HT victims and survivors.

Assessment of Protocol Development at UCSF Benioff Children's Hospital of Oakland as Recorded by HEAL Trafficking Consultant

SUCCESSES

The ongoing engagement of a multi-disciplinary team has been invaluable. UCSF Benioff Children's Hospital of Oakland (UBCHO) has had active participation from Adolescent Medicine, Center for the Vulnerable Child (CVC), Center for Child Protection, School-based Health Centers, Mental Health/Behavioral Health Integration team and the Dept of Psychiatry, Emergency Department, Pediatric Primary Care, Perioperative and OR team, Social Work, Office Associates and registration staff, Nursing Education, Leadership and administration. With their support, UBCHO went live with our Epic SafetyNet tool (discussed in detail in the technology section of this report) on 12/19/2018; this tool will facilitate identification, trauma-informed information sharing, referrals and data collection. UBCHO is working on having human trafficking education curriculum embedded in the community and advocacy rotation for all Children's residents. UBCHO very much appreciated the learning exchange between fellow institutions. Hospital champions from Highland and Kaiser met with them re: Children's Epic tools; UBCHO learned about Kaiser's domestic violence program and Highland's wonderful bedside advocate program. A more recent success is that UBCHO will be receiving some institutional and philanthropic support to expand its anti-trafficking work via the UCSF President's Innovation Fund.

UBCHO is pleased to receive IRB approval approval to lead interviews/focus groups with adult survivors of human trafficking to provide input re: its Epic SafetyNet tool and progress towards developing a machine learning tool to identify (and offer resources to) patients potentially impacted by (or at risk for) human trafficking. UBCHO has conducted several one-on-one interviews thus far. UBCHO has received very positive feedback from its providers about the comprehensive response protocol it developed as well as the more practical one-page version flow chart.

UBCHO has appreciated its collaboration with Dignity Health who has generously provided funding for several survivors to train health care providers at Children's. UBCHO looks forward to continuing to pilot the healthcare Commercial Sexual Exploitation Identification Tool in partnership with WestCoast Children's Clinic. UBCHO has also been collaborating with THORN to use technology to fight abuse and exploitation of youth.

CHALLENGES

When UBCHO first started this work years ago, it was a grassroots kind of effort with everyone working on aspects related to HT when they could find the time. There was no designated leader with protected time to facilitate the work. There was also a sense amongst providers that response services in the community were

fragmented. There was interest in streamlining the process to access support for patients, such as creating one call-in number where providers could leverage all the relevant agencies, potentially similar to the process in San Francisco, and inclusive of services for transitional age youth.

Another challenge is that it is unclear if labor trafficking is being adequately identified among patients and/or their families. There has been a lot of attention paid to sex trafficking, but UBCHO knows that the populations it serves are vulnerable to all kinds of human trafficking.

UBCHO has also faced some challenges due to the complexity of UCSF and Children's continuing the affiliation and integration process which takes up bandwidth and administrative time and effort. Turnover in roles (such as having a new FQHC medical director, staffing changes) can impact readiness to change and implement new protocols.

RECOMMENDATIONS

In terms of next steps, it will be critical to provide ongoing education to all providers in the Children's system re: responding to (and ideally preventing) human trafficking. Our plan is to integrate human trafficking education into one of the core residency rotations (the community and advocacy rotation). We are very grateful to the UCSF Benioff Children's Presidential Innovation Fund for supporting this effort.

As we enhance our ability to identify and offer support to patients impacted by human trafficking, it will be important to develop a simplified 24/7 coordinated case management response that is accessible to all hospital systems and that can ideally provide an appropriate and timely response.

It will also be important to provide ongoing monitoring or tracking of those victims/survivors who are identified within Children's, along with the ability to provide ongoing feedback about the effectiveness of the protocols. This feedback needs to include how the protocols are performing not only within each health system, but also regionally as well. This could be achieved by hospital-wide case or peer review that can address system issues or identify where changes may need to be made to address issues as the come up. Similarly, such peer or case review could be implemented regionally, particularly if cases demonstrate issues that are outside the scope of the individual hospital system of care and represent issues at the county level. Another example might be to have a regional HT oversight committee that can address particular policies and/or procedures that are, or are not working at the regional level, and that can help facilitate the various hospital organizations in working together, making necessary changes to their individual HT protocols, or to the broader county-wide HT protocol. This can ensure that all participating hospital organizations and the various county-wide HT serving agencies are effectively working together to address the needs of HT victims and survivors.

Protocol Flow Charts

The goals of the H.E.A.T. Institute – HEAL Trafficking pilot project were:

1) *for each hospital involved to develop and implement their own survivor-centered, trauma-informed human trafficking response protocol, based on guidance in the HEAL Trafficking Protocol Toolkit, and*
2) *for HEAL Trafficking to incorporate input from hospital champions/teams and community based organizations to create a standardized Alameda County Human Trafficking Response Protocol for all health care facilities in the region.*

This section of the report contains protocol flow charts from UCSF Benioff Children's Hospital Oakland, Highland Hospital, and Kaiser Permanente Medical 1Group – Oakland Medical Center, as well as the standardized Alameda County response protocol flow chart to support other health care settings in their development of protocols to respond to human trafficking.

The three hospitals' full length protocols are available in the separate appendix document.

Human Trafficking Response Protocol

Provide training on human trafficking (HT) and trauma-informed care to all staff to improve assessment and identification of impacted patients and facilitate response and referral.

For patients ≥ 11 years, explain confidentiality rules and spend at least part of the encounter interviewing patient privately, separated from any accompanying family members, friends, or partners.

Conduct a developmentally appropriate psychosocial risk screen (such as a HEADS assessment). If concerns come up, assess patient for HT risk using the tools available via Epic SafetyNet and CHONet.

No concern

Some concern

High concern

Prevention
- Universal education re: healthy relationships and consent
- Promote Healthy Oakland Teens app
- Encourage follow-up with PCP

Offer support
- Tell patient we are here to offer support; this is a safe space; the door is open
- Social work consult to address any unmet needs
- Make a follow-up apt with PCP
- Hope Intervention Program referral
- Obtain best contact info for follow-up

Mobilize a supportive response
- Tell patient we are here to support
- Social work consult to address needs
- For minors, mandatory report to Alameda County Child Abuse hotline at 510-259-1800
- Prioritize patient's safety
- Do not emphasize disclosure; meet patient where they are at
- Provide resources

If your patient does not speak English:
- get a trained interpreter to help
- give the patient the choice of an in-person interpreter (if available) or a phone based interpreter

If patient discloses exploitation/trafficking/abuse in Alameda County:
- Counsel patient they deserve better; they have rights; you want to help them
- If indicated, offer forensic services with the sexual assault response team
  - UCSF Benioff Children's Hospital Oakland if pt ≤ 13 yrs (510-428-3240)
  - Highland General Hospital if ≥ 14 years (510-437-4865)
- For minors, mandatory report to Child Abuse hotline 510-259-1800
- For adults, if there is a physical injury from an assault or firearm, complete mandatory report to law enforcement in the jurisdiction where injury occurred
- For adults, request permission to connect to advocacy services
  - If assents, contact appropriate organization based on age, type of exploitation, gender, sexual orientation
  - If declines, offer resources to support health needs and psychosocial situation
- If at any time an adult patient declines assistance, respect their decision and reiterate the door is open in the future.

Community Supports For Sex Trafficking:
BAWAR tel. 845-7273
C-CHANGE (WestCoast) tel. 517-9835
MISSSEY tel. 251-2070
Progressive Transitions (for adults) tel. 917-0666

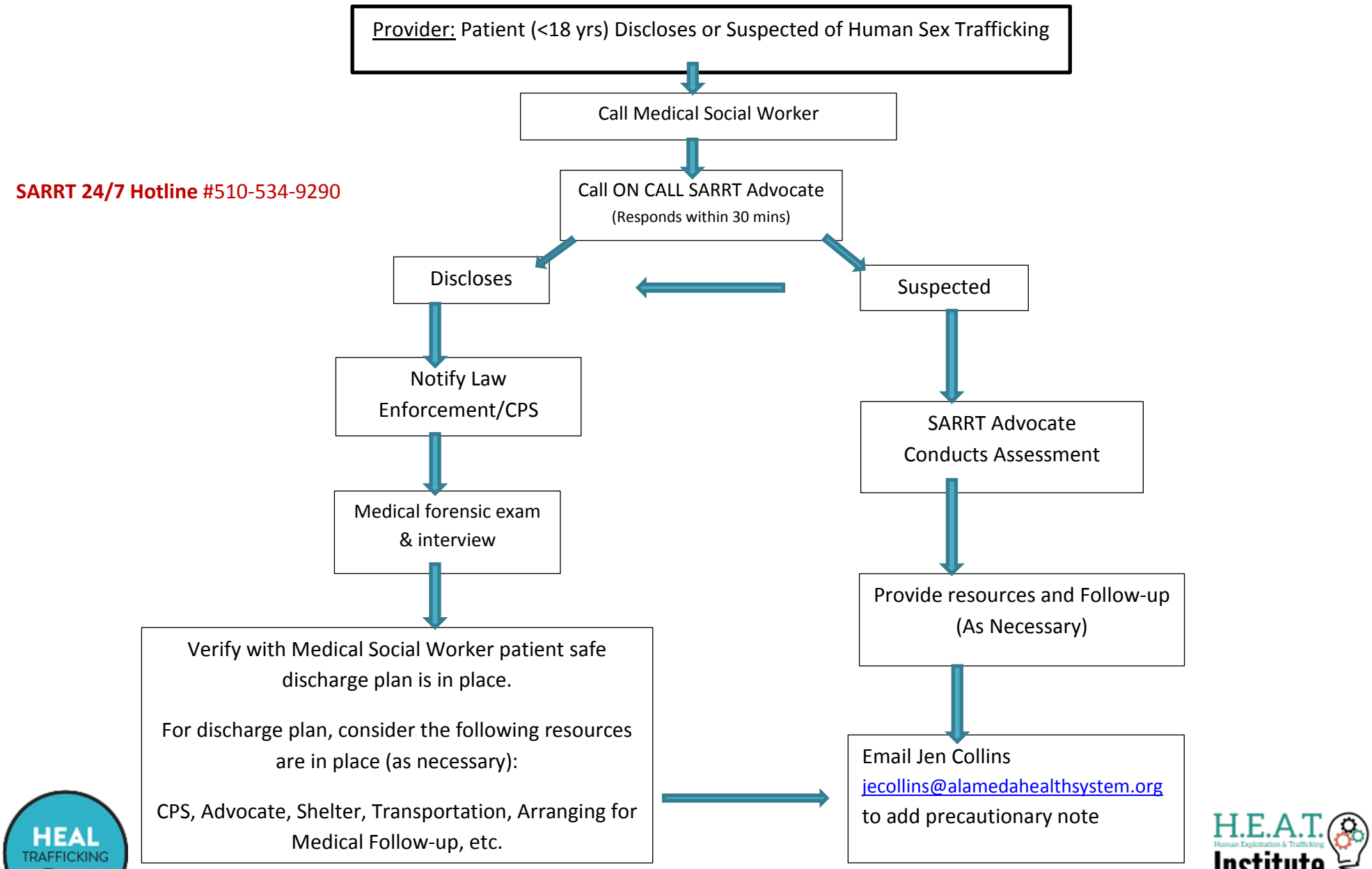
Community Supports For Labor Trafficking:
Alameda County Family Justice Center tel. 267-8800
APILO tel. 251-2846
IRC tel. 452-8222
Ruby's Place tel. (888) 339-7233

National Human Trafficking Hotline: 888-373-7888; SMS: 233733 (Text "HELP" or "INFO"); 24 hrs/7 days

UCSF Benioff Children's Hospital Oakland

Update every 6 months to access services for victims of of human trafficking regardless of country of origin, status of residency, gender, sexual and religious orientation, and language capacity. Contact www.211database.org and law enforcement at 911
Alameda County District Attorney Office H.E.A.T. Prosecutorial Unit - (510) 272-2666 (complex sex trafficking cases), ACDAO's Consumer Protection Enforcement Division-labor trafficking (510) 777-2294, Human Trafficking Inspectors (510) 272-6782, Local Tip Line -510-208-4959; SafetyNet for CSEC (510) 667-4370/ 667-4476 Training Needs - H.E.A.T. Institute (510) 891-8901; www.heatwatch.org **Mental Health**: **WestCoast Children's Clinic C-Change for CSEC (510) 517-9835**
Alameda County Department of Children and Family Services Child Abuse and Neglect Hotline: (510) 259-1800; Program Manager for day shift (510) 780-8604/ night shift (510) 780-8619; Emergency Response Unit (510)-670-9764
Alameda County Probation Department: Division Director for Commercial Sexual Exploitation Children (510) 268-7200
Local Sexual Assault 24 Hour Crises Responders: Tri-Valley Haven: 1-800-884-8119 (Dublin, Pleasanton, Livermore) and Bay Area Women Against Rape (510) 845-7273 and Progressive Transitions *(for adults)* (510) 917-0666 (Hayward, Oakland, Fremont, Emeryville, Berkeley, etc.)
Alameda County Child Family Assessment Center: The youth registration number provided when contacting Alameda County Child Abuse and Neglect Report Hotline: (510) 259-1800; concerns reported to Program Manager (510) 780-8947
Alameda County District Attorney Office Victim Witness Assistance Division (510) 272-6180
Local Medical Sexual Assault Response Sites: for Victims ≤ 13 years: UCSF Benioff Children's Hospital of Oakland: (510) 428-3240 and for Victims ≥ 14 years Highland Hospital in Oakland (510) 437-4865
Local 24 Hour Emergency Shelters: Ruby's Place: (888) 339-7233 for adults, Love Never Fails: (844) 249-2698 – 3 beds for female adult victims w/children, DreamCatcher: (800) 379-1114 -13 to 18 yrs; Covenant House California: (510) 379-1010 – 18 to 24 yrs. For non-system involved ≤ 19 yrs female CSEC with legal guardian's consent: contact@newdayforchildren.com
Asian Pacific Island Legal Outreach for training and immigration victim-witness advocates & attorneys (510) 251-2846/(510) 251-2292; **International Rescue Committee** for case mgt: (510) 452-8222
Alameda County Family Justice Center: (510) 267-8800 (ask for navigators); after 5 pm and before 8:30 am call 800-947-
Foreign Language Translation Services: Please follow your local protocols, use trauma-informed translators
CALICO aka Child Abuse, Listening, Interviewing, & Coordination Center (510) 895-0702; 524 Estudillo Ave, San Leandro, CA
Local Human Trafficking Survivor Support Groups: MISSSEY (510) 251-2070, S.H.A.D.E. Project (510) 306-5316

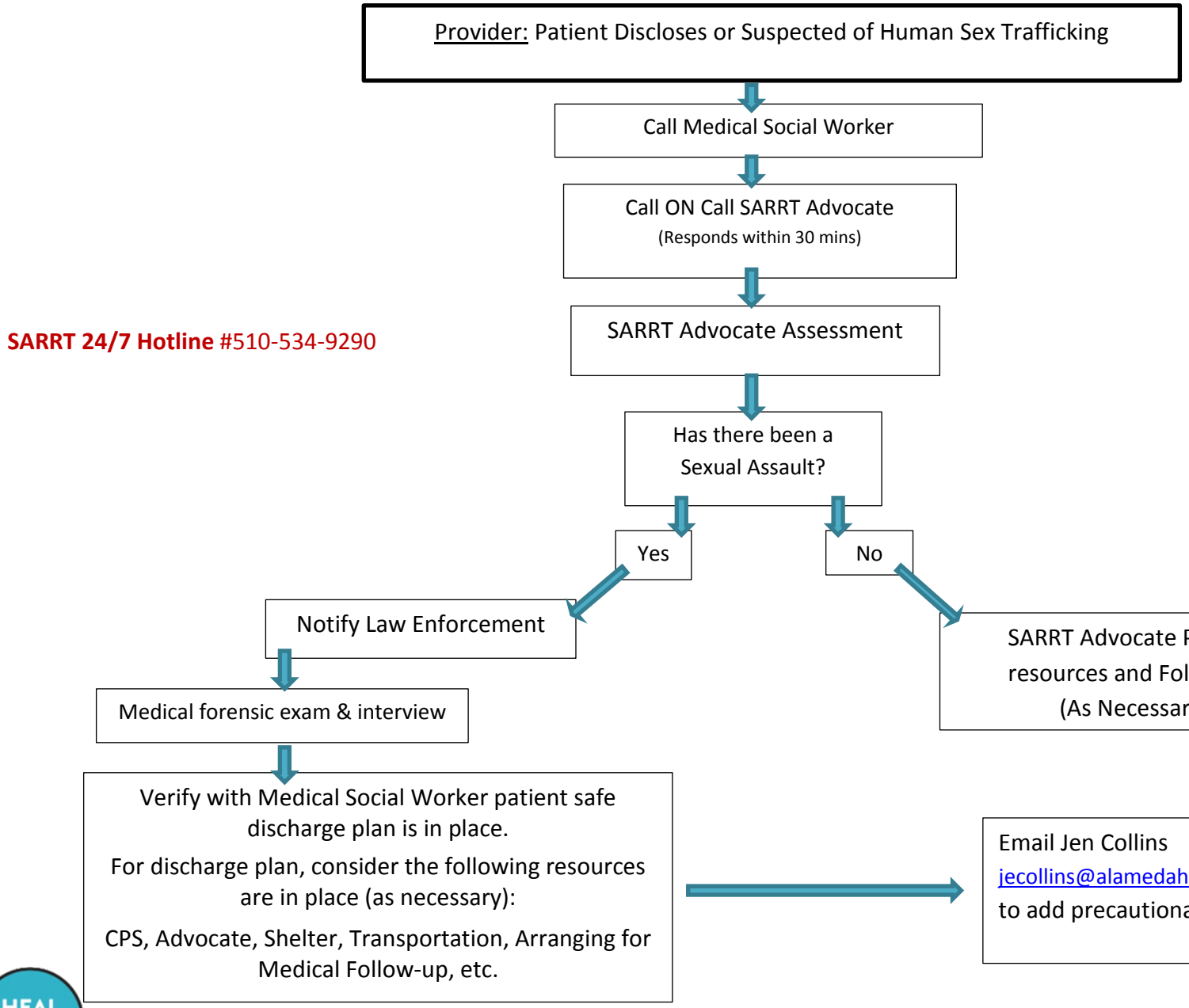
Updated March 2019 by



HEAL TRAFFICKING

H.E.A.T. Human Exploitation & Trafficking Institute

National Human Trafficking Hotline: 888-373-7888; SMS: 233733 (Text "HELP" or "INFO"); 24 hrs/7 days



SARRT 24/7 Hotline #510-534-9290

HEAL TRAFFICKING

H.E.A.T. Human Exploitation & Trafficking Institute

National Human Trafficking Hotline: 888-373-7888; SMS: 233733 (Text "HELP" or "INFO"); 24 hrs/7 days

Updated October 2018

STEP 1 HUMAN TRAFFICKING

Create Safety

Normalize – growing issue in our community

Provide universal education about interpersonal violence and health

ROOM ALONE
Assess/ screen patients for HT
- Show warmth and concern
- Tend to basic needs and the patient's primary concerns BEFORE trafficking related questions
- Ensure privacy, separate from controlling accompanying person if not roomed alone
- Explain limits of confidentiality

RED FLAGS

- Carrying large amounts cash
- Doesn't have ID documents
- Unable to give their address, doesn't know current city
- Inconsistent/scripted history
- Hyper-vigilance, subordinate behavior
- Accompanied by controlling person +/- doesn't allow patient to answer, interrupts
- Unusual occupational injuries
- Branding tattoos
- Multiple STI or pregnancies, abortions

1. Reassure patient of safety and our goal of support
2. Emphasize support NOT DISCLOSURE
3. Alert Security: NO visitors until you have had sufficient time to assess safety
4. **Designate team member** as main interviewer. Minimize staff who interact with the patient
5. Suspected trafficking in FAMILY COMMENTS
6. Plan for team mobilization:
   - Alert Trafficking champions PRN
   - Follow STEP 2 Pediatric High concern/Disclosure Pathway. ALWAYS make CPS report
   - Follow STEP 2 Adult High Concern/Disclosure Pathway

OFFER MEDICAL CARE AND SOCIAL RESOUORCES
If patient declines assistance, respect their decision (excluding mandatory report)

MEDICAL

ADDRESS patient's main concern
OFFER Mental Health assessment/support
OFFER Reproductive Health Options
- STI prophylaxis as needed
- Emergency contraception
- Long-term contraception: PEDS consult to place implant as desired by teen patients. GYN consult if **confidential** IUD placement desired

SOCIAL

Reference STEP 2 flow sheet for pediatrics and adults

Reference HT binder for more extensive resources: resources organized by age, gender identity, type of exploitation, need (legal/housing/mental health)

Kaiser Permanente Medical Group – Oakland Medical Center

STEP 2 PEDIATRIC HIGH CONCERN/ CONFIRMED TRAFFICKING

CSEC: Commercially Sexually Exploited Children | **Labor Trafficking**

1. **Demonstrate a culture of support and dignity.**
2. **Meet any acute physical and mental health needs: offer mental and reproductive health options**
3. **Mobilize/ Huddle with CASP/SW once suspicion for trafficking is high to aid in reporting and resources**
4. **Work with child abuse team (CASP, SW, MH) to ensure SAFE DISPOSITION**

NEED HELP? Consult CASP MD lead (510) 318-0682

COMPLETE Mandatory Report of Child Abuse, Scar form and call CPS 510-259-1800
For ALL confirmed or high suspicion cases

No injury
No sexual assault

1. Complete in depth assessment (CSE-it tool)
2. Complete CPS form Scar
3. Alert SafetyNet 510-667-4476

Sexual Assault or INJURY+ HT

1. Contact LE in county where assault /abuse occurred (see abuse website for numbers)
2. Complete Scar +Cal EMA 2900 +suspicious injury for physical injury
3. TRANSFER for SART evidentiary exams in Alameda:
   - CHO transfer ≤13 y/o
   - HGH transfer ≥14 y/o

No injury
No sexual assault

1. Complete in depth assessment
2. If patient discloses and wants to make a report, call non emergency dispatch 510-777-3333
3. If patient discloses and trafficker is imminent threat, call 911 (rare)

MISSSEY: 510-251-2070
C-Change: 510-517-9835

Offer social, legal, MH resources: SEE BINDER

IRC: 510-852-8941

Determine Safety

Imminent Danger;
Parent/Guardian is suspected trafficker

1. SW aids in search for community bed: Dreamcatcher 800-379-1114, Ruby's place 888-339-7233, Covenant House 510-379-1010
2. Alert CASP MD of need for ADMISSION

1. SW aids in search for community bed: Ruby's place 888-339-7233,
2. Alert CASP MD if need for ADMISSION

Safe living situation

KP PCP
- E-consult Adolescent Medicine for FU
- E-consult CASP

No PCP
- Referral to CHO
- Offer medical FU with OAKLAND teens app

STEP 2 ADULT HIGH CONCERN/ CONFIRMED TRAFFICKING

Sex Trafficking | **Labor Trafficking**

1. **Demonstrate a culture of support and dignity**
2. **Meet any acute physical or mental health needs: offer mental and reproductive health options**
3. **Mobilize SW/MH teams as needed: offer shelter, legal aid, mental health resources (HT binder)**
4. **Respect patient's decision to accept/refuse resources**

NEED HELP?
Consult HT team
MD lead
(510) 914-0775

Complete Mandatory Report as indicated below (abuse website)

- Trafficker = Partner: Follow IPV reporting
- NO injury, sexual assault, or IPV: No mandated report
- (+) Injury, no sexual assault or IPV: Follow assault reporting
- Sexual assault + Human Trafficking +/- IPV

1. Call law enforcement for county in which assault occurred to report (abuse website)
2. BAWAR 510-854-727 for patient advocate to bedside
3. **TRANSFER** for SART exam, location per LE

Disclosing HT

1. Patient **wants to make a report**, call OPD non emergency dispatch 510-777-3333
2. Patient **wants to report and trafficker is an imminent threat**, call 911
3. Document suspected trafficking in FAMILY COMMENTS

Not disclosing HT

Safe housing
Not ready to leave

1. Offer resources (HT binder):
   a. IRC 510-452-8222
   b. Asian Pacific Islander Legal Outreach 510-251-2846
   c. Justice at Last Legal Services 650-995-4893
   d. Legal Aid Society Employment Law Center 866-864-8208
2. KP: ensure close MD FU. Document concerns in chart
3. Non KP: refer to HGH for PMD

1. Offer resources (HT binder): Ruby's Place 888-339-SAFE, Progressive Transitions 510-917-0666
2. KP: ensure close PMD FU. Document suspected trafficking in dx
3. Non KP: refer to HGH for PMD, Safety Net

Imminent Danger
Seeking emergency shelter

- Bedside advocate: Progressive Transitions 510-917-0666
- Emergency shelter: Ruby's place 888-339-SAFE, 510-303-9953
- HT binder for more resources

- Case Management: IRC 510-452-8222
- Emergency shelter: Ruby's place 888-339-SAFE, 510-303-9953
- HT binder for more resources

Alameda County Standardized Human Trafficking Response Protocol for Victims in Health Care Settings

Provide basic training on human trafficking and trauma informed care for clinical and non-clinical staff to improve assessment and identification of impacted patients and improve response and referral processes

Normalize

Build Rapport

Assess/screen patients for HT and other forms of interpersonal violence in private, safe space:

- Show warmth, care and concern for patient
- Tend to basic needs before interviews
- Separate patient from controlling accompanying person, including family members
- Explain limits of confidentiality

Provide Universal Education about Violence & Health

Staff observation, assessment/interview, or clinical exam leads to concern that patient may be in trafficking situation

No Concern

Prevention

- Healthy relationships
- Immigrant & worker rights
- Secure housing
- Harm reduction

No Disclosure

- **For adult** - request permission to connect patient with referrals, advocacy services
- If at any time patient declines assistance, respect their decision
- **For minor** – mandatory report. **Call CPS Hotline and law enforcement where abuse occurred, otherwise call Alameda County Child Abuse Hotline 510-259-1800.**
  For minor –consent required, call SafetyNet 510-667-4476
- Offer resources to support life & health needs – meet patient where they are **(Stages of Change hand-out)**
- Enter appropriate documentation in medical record, using discretion, and avoiding stigmatizing language

Suspected Labor Trafficking:

Ruby's Place 24 hrs hotline: (888) 339-SAFE to access referrals to IRC, APILO, ACFJC.
See back for resources.

Suspected Sex Trafficking:

BAWAR 24 hrs hotline: 510 - 845-7273 or TRI-Valley 1-800-884-8119 to access volunteers & referrals to MISSSEY, WCCC, ACFJC, & Progressive Transitions 510-917-0666 for adult victims.
See back for resources.

Some Concern

- Tell patient you are here to support them, reassure this is safe space, door is open to them
- Do not emphasize disclosure but meet person where they are (Please review your Stages of Change hand out)
- Prioritize patient's safety
- Minimize number of staff who interact with patient
- Make follow up appointment
- Obtain best and alternate contact information for patient follow/up
- Provide patient clinical and social resources, contact information
- Social work consult
- For inpatient admissions, allow patient to opt out of hospital directory

Disclosure of Exploitation/Trafficking/Abuse in Alameda County

- Counsel patients they deserve better; they have rights; you want to help them
- If at any time patient declines assistance, respect their decision (excluding mandatory report)
- **Offer forensic services with sexual assault response team (SART) as indicated; does not require reporting to law enforcement (LE) in the jurisdiction where sexual assault occurred. Affected patients may request an exam and not be charged for services. If LE is involved, they may arrange for SART exams.**
  - Children's Hospital Oakland if patient<13 yrs (510-428-3240)
  - Highland General Hospital if > 14 yrs (510-437-4865)
- Request permission to connect patient with advocacy services
  - If consent, contact appropriate organization based on age, type of exploitation, gender, sexual orientation
  - If declines, offer resources to support health needs and psychosocial situation
- Minor – mandatory report call 510-259-1800 County Child Abuse Hotline and contact Alameda County SafetyNet at 510-667-4476
- Adult – mandatory report only in cases of physical injury from a firearm or assault. Call goes to LE in jurisdiction where assault occurred. Obtain patient consent to notify law enforcement. If otherwise indicated (call 911). If patient is a prior CSEC victim and has given consent, contact SafetyNet 510-667-4476
- Enter appropriate documentation in medical record

High Concern

FREQUENTLY CONTACTED ORGANIZATIONS - UPDATE EVERY 6 MONTHS:

www.211database.org and Law Enforcement: 911

Alameda County District Attorney Office H.E.A.T. Prosecutorial Unit - (510) 272-6222, Consumer Protection Enforcement Division-Labor Trafficking (510) 777-2294, Human Trafficking Inspectors (510) 272-6282, Local Tip Line -510-208-4959; SafetyNet for CSEC (510) 667-4370/ 667-4476, Training Needs - H.E.A.T. Institute (510) 891-8901 and HEAT Watch www.heatwatch.org (510) 272-6222, Victim Witness Assistance Division (510) 272-6180 for Human Trafficking Advocates
Alameda County Department of Children and Family Services Child Abuse and Neglect Hotline: (510) 259-1800; Program Manager for day shift (510) 780-8604/ night shift (510) 780-8619; Emergency Response Unit (510)-670-9764
Alameda County Child Family Assessment Center: A youth registration number is provided by County Child Abuse and Neglect Report Hotline: (510) 259-1800; concerns should be reported to Program Manager (510) 780-8947.
Alameda County Probation Department: Director for Juvenile Division including CSEC (510) 268-7200
Local Sexual Assault/Sex Trafficking 24 Hour Crises Responders: Tri-Valley Haven (800) 884-8119 (Dublin, Pleasanton, Livermore); in Hayward, Oakland, Fremont, Emeryville, Berkeley: SHADE Movement Project (510) 306-5316 and Bay Area Women Against Rape (510) 845-7273 (particularly for CSEC) Progressive Transitions (for adults) (510) 917-0666; and Highland Hospital Rape Crises also known as Highland Hospital Sexual Assault Center (510) 534-9290 or 510-534-9291 (countywide)
Local Medical Sexual Assault Response Sites: for Victims < 13 years: UCSF Benioff Children's Hospital of Oakland: (510) 428-3240, and for Victims ≥ 14 years: Highland Hospital in Oakland (510) 437-4865
WestCoast Children's Clinic C-Change for CSEC: (510) 517-9835 for mental health services for CSEC victims that have full scope MediCal Insurance or have been previously seen by WCCC Counselors.
UCSF Benioff CHO Adolescent Teen Clinic: (510) 428-3000 for unmet health heeds. Additional clinics may be found on the Healthy Oakland Teens app which can be accessed from Google Play and Apple iTunes Store.
Local 24 Hour Emergency Shelters with Human Trafficking Case Management: Ruby's Place: (888) 339-7233 for adults, DreamCatcher: (800) 379-1114 13 to 18 yrs; Covenant House California: (510) 379-1010 – 18 to 24 yrs. Transitional Housing: Love Never Fails: (844) 249-2698 – 3 beds for female adult victims w/children; and New Day for Children: please contact@newdayforchildren.com - non-system involved female CSEC age ≤ 19 yrs with legal guardian's consent.
CALICO aka Child Abuse, Listening, Interviewing, & Coordination Center (510) 895-0702; 524 Estudillo Ave, San Leandro, CA
Human Trafficking Survivor Support Groups and Training: MISSSEY (510) 251-2070 and S.H.A.D.E. Project (510) 306-5316
LGBTQ Support Groups and Training: Side by Side's Our Space (510) 727-9401 or OurSpace@sidebysideyouth.org
Support for Foreign Nationals: Asian Pacific Island Legal Outreach: (510) 251-2846/(510) 251-2292 for training and immigration victim-witness advocates & attorneys; International Rescue Committee: (510) 452-8222 for case management.
Alameda County Family Justice Center: (510) 267-8800 (ask for navigators); after 5 pm/ before 8:30 am call 800-947-8301
Foreign Language Translation Services: Please follow your local protocols, use trauma-informed translators
National Human Trafficking Hotline: 888-373-7888; text: 233733 (Text "HELP" or "INFO"); 24 hrs/7 days
National Sexual Assault Hotline: 1-800-655-HOPE (4673) and StrongHearts Native Helpline: 1-844-7NATIVE (762-8483)
National Runaway Safeline for Runaway and Homeless Youth: 1-800-RUNAWAY (786-2929)
National Domestic Violence Hotline: 1-800-799-SAFE (7233) and National Suicide Prevention Lifeline: 1-800-273-8255

Special Topics

These topics were discussed in Regional Learning Exchange meetings, and also highlight some of the unique approaches that the participating hospitals are using to address challenging issues.

Human Trafficking as a Child Welfare Issue

Electronic Health Records and Human Trafficking

Use of a Sexual Assault Response and Recovery Team for Sex Trafficking Response

Human Trafficking is a Child Welfare Issue

The California Commercially Sexually Exploited Children (CSEC) Program launched in the Department of Health and Human Services in 2015 following the passage of California SB 855, which clarified that child sexual exploitation is child abuse and falls under the jurisdiction of child welfare agencies. While 38 counties currently participate in the program to provide multidisciplinary responses for identifying and serving CSEC and at-risk children, responses vary highly from county to county and significant gaps remain, leaving youth at risk.

During this pilot protocol project, the Alameda County Department of Children and Family Services (DCFS) participated in the Regional Learning Exchange (RLE) meetings as well as individual launch meetings at Highland Hospital and Alta Bates Sutter Medical Center. DCFS clarified expectations for when calls are made to the County's Child Abuse Hotline and provided data about CSEC cases in their dependent population; they did not participate in the hospitals' internal protocols development work.

Conversations about DCFS at the individual hospital launch meetings for protocol development and the Regional Learning Exchange meetings (which included the project leadership, hospital champions and team members, community-based organizations, and survivors) revealed concerns about the lack of effective and trauma-informed policies to guide the response to youth impacted by human trafficking in Alameda County. Attendees identified opportunities for improving processes and collaboration between DCFS and health care providers.

Recommendations

1. Need for dedicated Human Trafficking teams within Alameda County's DCFS

   Health care providers expressed concerns about receiving misinformation from Alameda County Child Abuse Hotline. They expressed that ongoing staff rotations and the lack of specialized teams of social workers and investigators to respond to CSEC cases increases the risk for misinformation; unprepared DCFS staff have precipitated discouraging and frustrating interactions with hospital staff. For example, in the preceding year, when a provider called regarding a CSEC concern, the provider was told to call the police to report the concern and was never advised if an investigation was opened. The health care providers stressed the need for accurate and current information to make formal reports and to follow up on referrals made to DCFS, and for relevant advice from DCFS with regard to CSEC.

2. Need for improved collaboration with health care providers and Community Based Organizations

   Health care providers commented on the lack of transparency in DCFS engagement with health care providers, their responses to suspected CSEC cases called in by health care providers, and investments to support CSEC. This lack of transparency and collaboration limits joint development of effective and innovative approaches. For example, the CSEC Steering Committee working sessions led by DCFS have not been consistently convened to openly discuss goals, strategies, investments, and benchmarks of progress. The meetings have devolved to developing the CSEC Memorandum of Understanding, an undertaking that began in 2015 and had not yet been finalized as of December 2018. Neither Highland Hospital nor UCSF Benioff Children Hospital, the two main health providers for medical clearance of dependents and medical forensic providers, have been regularly invited or engaged in strategic decisions or innovative problem solving around the DCFS CSEC response.

   DCFS staff attends SafetyNet meetings, which allow for confidential information exchange between multidisciplinary agencies, but they do not actively participate in the case reviews, stating that the information they have about CSEC in their care is confidential. With an MOU in place, DCFS workers could be trained to understand their role in the wrap-around team, contributing their knowledge about specific youth to ensure their well-being and allow for coordination of services.

3. Simplify resource coordination and referrals for service providers and health care providers by providing centralized communication, so that when health care providers call in a CSEC report, they can access one primary point for dispatch of community-based services to interface with patients.

   Alameda County health care providers were surprised to learn that when San Francisco (SF) County providers call their child abuse hotline, the operators ask if the provider thinks the youth for whom the report is being made is CSEC. This indicates the preparedness of SF County's child abuse hotline in training staff and developing internal protocols to respond to the needs of these youth. Another distinguishing factor between the two county protocols is that in SF County, the Human Services Agency contracts with Huckleberry Youth Programs to provide a 24/7 trauma-informed response and comprehensive services for CSEC youth through the Huckleberry Advocacy & Response Team (HART). HART staff will meet youth at the hospital to provide prompt support.

   In Alameda County, DCFS does not provide such support. Instead, if a caring adult cannot provide safety to the minor, they are transferred by law enforcement to the DCFS Assessment Center. Health care providers question this procedure because CSEC youth are not criminals and the involvement of law enforcement can create undue stress. A trauma informed approach for CSEC response is

needed in Alameda County, including dispatch of well-trained and supported advocates to come to hospitals to support CSEC youth.

Currently, Alameda County lacks a coordinated communication point to dispatch community based services providers that can interface with patients when health care providers call. DCFS is the agency that needs to ensure that such a network exists. DCFS does resource WCCC (WestCoast Children's Clinic) and MISSSEY (Motivating Inspiring Supporting Serving Sexually Exploited Youth) staff to support youth at the Assessment Center. However, DCSF must also ensure that these partners provide consistent follow through. Health care providers strongly voice the need for DCFS funded bedside advocates. CSEC trained advocates like Survivors Healing Advising Dedicated to Empowerment (S.H.A.D.E.), Bay Area Women Against Rape (B.A.W.A.R.) and Progressive Transitions provide mobile advocacy, yet they are not funded by DCFS to respond to CSEC. Without support, their resources are inadequate to respond at hospitals and coordinate intermediate care to meet the unique needs of CSEC.

Community based organizations may provide overlapping services. Without DCSF playing a role in managing the volume and specific needs of children they are following, the county risks inefficient double services, over-referral, and potential exhaustion of resources from one organization.

SF County protocols could potentially serve as a model for refinement of the Alameda County CPS response to human trafficking, though Alameda County can build on this system to also incorporate a response to children exploited for labor.

4. Improve the Assessment Center. The participants discussed the significant challenges in the DCFS Assessment Center, which contributes to it being a triggering and traumatic environment for vulnerable youth, and as such has inadvertently contributed to CSEC recruitment. Problems identified by health care providers include:

    a. Varied ages mixed together with potential for intimidation and ongoing abuse
    b. Open Assessment Center lacking focus on immediate need for safety and placement
    c. Lack of trauma-informed holding areas and care/interviews
    d. There is no mechanism in place to support youth who opt not to stay at the Assessment Center

5. Follow up and provide feedback: Participants expressed concern about inability to obtain feedback regarding referred cases

    a. DCFS has improved their confidentiality protocols, but this often leaves the caller (i.e. referring provider) without sufficient information.
    b. Many CSEC children are caught in a cycle of violence and intimidation. They may interface with multiple health care systems without these systems having the capacity or the guidance to effectively coordinate and share information with DCFS.

6. Increase support for transitional age/ non-minor dependent CSEC.

    a. Participants felt that DCFS lacked appropriate protocols and bandwidth to effectively deal with the complexity of ongoing abuse as teenagers reach 18. Health care providers reported that DCFS has told them "they don't have anything to offer" approaching the age of 18. Community based organizations like Bay Area Legal Aid and the East Bay Law Center for Children shared their challenges in navigating the legal technicalities to safeguard and reinstate benefits for non-minor dependent youth until they turn 21. However, legal advocacy is not sufficient and more resources are needed to strengthen the safety net to support these young adults as they deal with their complex trauma. The impact of CSEC includes parenting, a common trend among female CSEC, which complicates their ability to maintain safety and security.

    b. Participants expressed a similar concern with regard to the State of California and therefore DCFS' unsatisfactory response to labor trafficking. At present DCFS, like most of California's child welfare agencies, has not developed a response to labor trafficking among minors. In fact, many agencies will not recognize child labor trafficking as abuse if there is no physical injury to report. This is common throughout the state because all California efforts have focused on child sex trafficking, but child labor trafficking victims are also badly traumatized and in need of services.

In conclusion, the child welfare response is critical to creating a trauma-informed response to trafficked youth in Alameda County. DCFS has the responsibility to work with agencies in the County to coordinate services for trafficked youth and ensure that personnel within the Department, as well as those in partner and contracted agencies, are adequately educated on the issue and on appropriate protocols. DCFS should improve collaboration with health care providers by developing clear guidelines and referral procedures for hospitals, clinics, and school based health centers to follow, in order to safely transition exploited and trafficked youth from medical care to emergency advocacy, safe shelter, and ongoing wrap around services.

Electronic Health Records and Human Trafficking

ICD-10 Codes for Trafficking

On June 1, 2018, the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC) added new data collection fields for human trafficking. These ICD-10-CM codes went live October 1, 2018 and are available to document patient encounters and discharges occurring from October 1, 2018 through September 30, 2019. They include codes for suspected or confirmed "child sexual exploitation," "adult forced sexual exploitation," "child forced labor exploitation," "adult forced labor exploitation," and others. [See attached American Hospital Association Fact Sheet for more information.] Each individual institution has their own processes and time frames for uploading these new codes into their systems; no mandate for their use exists.

Per the U.S. Department of Health and Human Services Office of Trafficking in Persons, "the Office on Trafficking in Persons and the HHS Office on Women's Health consulted with the CDC and health care provider stakeholders (e.g. American Hospital Association, HEAL Trafficking, International Center for Missing and Exploited Children) on strengthening data collection on human trafficking within health care settings. The new ICD-10 codes allow health care providers and hospitals to adequately differentiate victims of human trafficking from other abuse victims."

The creation of these codes also allows, for the first time, data collection at the national level on the prevalence of human trafficking victims and survivors in health care settings, and health issues they experience. However, because not all hospitals or health care providers will use the codes, and because providers as well as billers and coders require training on human trafficking in order to understand use of the codes, any data collected will underestimate the prevalence of people who present to health care with indicators that they may be a human trafficking victim. In addition, research studies demonstrate that many victims are unable to access health services due to the control of their trafficker.

ICD-10 codes for human trafficking make it possible to track health outcomes for patients impacted by human trafficking. The codes also potentially allow for continuity of care in addressing the issue, because once a diagnosis is entered in a patient's electronic health record (EHR) other health care personnel seeing the patient within that EHR system will also see the diagnosis in the patient's problem list and in notes from prior encounters.

Health care providers and staff need a mechanism through which they can document their concerns that a patient may be trafficked, particularly for patients who cannot or will not disclose their exploitation. Victims may visit emergency departments, urgent care, obstetricians-gynecologists, family planning clinics, and other health care settings multiple times,[1,2] so one provider's concerns can be subsequently addressed by another if there is a safe and confidential process to use to communicate one's concerns. Use of the diagnostic code could be particularly helpful for emergency departments (EDs), which share data

through the Emergency Department Information Exchange (EDIE), a software tool for proactively notifying EDs when high-utilization or special needs patients register. The information includes those patients' prior ED visit history, primary care provider information, and associated care plans.[3]

Other Mechanisms to Document Suspicion of Human Trafficking

However, more subtle documentation may be safer and less stigmatizing to the patient than utilization of ICD-10 codes, particularly in the absence of mandatory reporting requirements.* The *HEAL Trafficking Protocol Toolkit for Developing a Response to Human Trafficking Victims in Health Care Settings* (HEAL Toolkit) suggests that documentation of resources provided to the patient can serve as an indicator to other providers that there are concerns that the patient could be a victim of trafficking. For example, providers can write, "Gave patient National HT Hotline number" or "Referred to community agency X, shown HT brochure." Should a subsequent provider read the note of a colleague to learn about the patient's last visit, they will acquire this information, and can document the presence of continued concern if indicated. ICD-10 codes, on the other hand, become permanently embedded in the chart and may follow the patient indefinitely. This also becomes a problem when patient is labeled as an exploited or trafficked person but does not identify that way. Some will resent being labeled at all; many will recover from their situation and become "survivor thrivers" who are not in jeopardy. These patients are now burdened with a stigmatizing diagnosis that can bring negativity and frustration to encounters with health care providers, who may dwell on that issue rather than the patients' current identities, needs, and desires.

Thus, while there are benefits to the new codes, they also pose a risk, given the stigma, privacy, and potential legal issues they create. Use of the codes requires an understanding of their potential harms as well as consistent use of best practices in trauma-informed, patient-centered care. This includes considering the implications of suspected or confirmed trafficking codes placed on after-visit or discharge summaries. *Health systems should consider preventing sensitive diagnoses from appearing on discharge summaries.* Similarly, if a patient logs into a patient portal (such as MyChart with Epic), sensitive diagnoses should not be displayed.

In addition, any disclosure of medical records to a third party should limit the disclosure of human trafficking codes, unless the patient has given explicit permission to share this diagnosis. While a provider who is caring for a minor impacted by human trafficking may think it will benefit a patient and their care team to list a human trafficking related ICD-10 diagnosis, use of the code could also put the patient in jeopardy. The parent or guardian of

* Currently, in California human trafficking mandatory reporting requirements only explicitly exist for child sex trafficking and commercial sexual exploitation of children; suspected trafficking of an adult does not require reporting unless the clinician provides medical services to a patient whom they suspect is suffering from sexual assault or a physical injury due to a firearm or assaultive or abusive conduct. Child labor trafficking is reportable as child abuse, but most child protective services agencies have not been trained to respond to child labor trafficking victims.

the minor, or someone posing as such, may request their records. If the code or its associated diagnosis is not removed from the records for its sensitivity, the victim may experience punishment, including physical violence, for having spoken to a health care provider about their exploitation—even if they did not. It is important to remember that intrafamilial human trafficking is frequently reported by survivors.

As noted in the HEAL Toolkit, because of the complexity of medical-legal issues around trafficking cases and great variation in state and local laws, guidelines for optimal documentation practices with potential victims should be developed in consultation with local prosecutors, defense attorneys, and advocates. Depending on the legal climate, entering more or less information in the patient's chart can either be harmful or helpful. Unfortunately, many EHR systems do not incorporate refined mechanisms to determine which confidential information gets shared when records are requested. Information in the medical record can potentially be harmful to the patient when their case goes to trial (e.g., if a sex trafficking victim contracts HIV, in some states they could be criminalized for the transmission of HIV). In many jurisdictions, crimes committed by trafficking victims while under the control of their trafficker will be prosecuted (e.g. a patient coerced to sell sex or use or sell drugs may still be charged with these crimes); therefore, health care providers should avoid entering information about potential criminal activity in the medical record. The HEAL Toolkit also mentions that inclusion of survivor quotes in the medical record is often advised in cases of injury or sexual assault, but that such details about a human trafficking survivor's story may not be helpful. Because of their histories of trauma and complex trauma, which greatly impact memory, and because they are trained by their exploiters to lie, the accounts trafficking victims relay to health care providers may differ from what they share later, with other providers, or with law enforcement, case managers and attorneys. Should such inconsistencies ever come to light in a court case, the survivor's credibility would be jeopardized. Importantly, sensitive information in the medical record may or may not be redacted during a court hearing or trial depending on whether the state in which the crime occurred has a rape shield law, and if that state has determined that the rape shield law applies to trafficking victims. (A rape shield law is a law that limits a defendant's ability to introduce evidence or cross-examine rape complainants about their past sexual behavior.)

EHR Reforms at UCSF Benioff Children's Hospital Oakland

At UBCHO, to maximize the delivery of trauma-informed care, a multi-disciplinary anti-trafficking working group, comprised of health care providers (physicians, nurses), social work, and mental health providers collaborated with the health information management and privacy team, Epic EHR analysts, risk management, and survivors to develop an EHR tool called the Epic SafetyNet tool (Figure 1, below). Epic is the name of the electronic health record system used at the hospital, and the SafetyNet tool is built using Epic's Smart Form, a clinical decision support system that enables writing a multi-problem visit note while capturing coded information and providing sophisticated decision support in the form of tailored recommendations for care.[4] UBCHO's SafetyNet tool is 'internal facing' so even if medical records are requested, the information in SafetyNet is not subject to release. The system provides the capability for members of the health care team to turn on

(and turn off) an alert banner that says SafetyNet, which has links to best practices. It collects demographic information and has built in screening/identification support for providers (currently the medical CSE-IT, a shortened version of West Coast Children's Clinic's Commercial Sexual Exploitation – Identification Tool; in the future it will also incorporate a labor trafficking-related tool). Social work consults and facilitated referrals to youth support services are built in to the system, including the community based agencies West Coast Children's Clinic (a mental health service provider); Bay Area Women Against Rape (BAWAR), a rape crisis center that provides services, counseling, and advocacy on a 24/7 basis; and Motivating, Inspiring, and Supporting and Serving Sexually Exploited Youth (MISSSEY). The system faxes referral using a common referral form that WestCoast Children's Clinic, MISSSEY and BAWAR developed with UBCHO during the protocol development process. This referral form is also the basis for the referral form created by Ruby's Place and Progressive Transitions. SafetyNet also incorporates a confidential care coordination section and has the ability to provide data reports, a feature lacking in some EHR systems. Currently, the SafetyNet tool can only be used on site at UBCHO.

Dr. Lela Bachrach, HEAL Trafficking's consultant for UBCHO as well as its internal hospital champion, notes that more work needs to be done to develop best practices for information sharing between institutions. The Epic SafetyNet tool does not show up via CareEverywhere, Epic's inter-institutional information sharing mechanism. However, providers can include a generic ICD-10 code on the patient's problem list, such as 'psychosocial stressors," that could potentially trigger social work support at another institution where the patient presents, without compromising their privacy or stigmatizing them with a label.

Two other hospital systems involved in the pilot project, Highland Hospital and Kaiser Oakland, are initiating use of Epic EHR. Dr. Bachrach; Dr. Suzanne Lippert, a pilot project champion at Kaiser; and Hillary Larkin, PA, domestic violence and sexual assault response expert at Highland, met to discuss strategies for balancing the sharing of information through Epic with maintaining confidentiality of sensitive patient information.

Dr. Nia Stallworth, a resident physician at Highland, is working with Dr. Bachrach to convene focus groups of survivor patients and clients to evaluate their experiences with the UBCHO SafetyNet system. The focus group process is expected to be completed in June 2019; this work will inform future data sharing among the hospitals. Meanwhile, Dr. Lippert is meeting with the Chief of Information Technology about designing an Epic Smart Form to flag factors and track patient care through the Kaiser Permanente system of northern California region. At Highland, Ms. Larkin has led use of the Domestic Violence Reporting and Referral tool, a novel tablet-based application, in conjunction with the Alameda County Family Justice Center. The tool is designed to fulfill California providers' mandatory reporting duty while simultaneously uploading reports to law enforcement, prosecutors and advocates. Ms. Larkin notes that as Highland prepares for implementation of Epic, there is an increased focus on managing all the necessary reporting including to law enforcement, Alameda County Department of Children and Family Services, and the state of California.

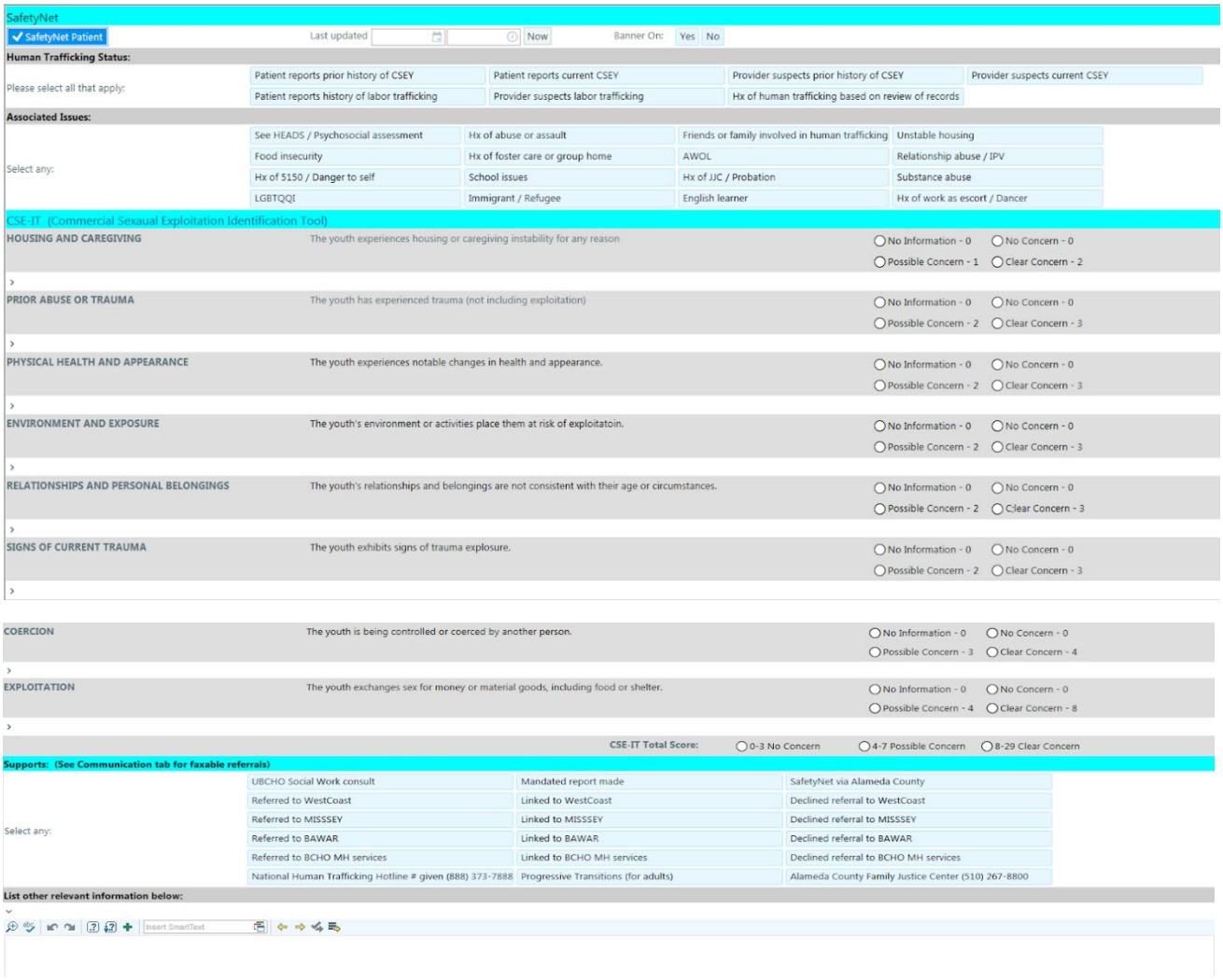
Dr. Bachrach also highlights that some regions have developed MOUs to allow sharing of information between medical and non-medical providers involved in the care of commercially sexually exploited youth through multidisciplinary teams. For example, in Alameda County, the SafetyNet meeting involves collaboration between criminal justice, child welfare, education, and health care agencies and providers. Dr. Bachrach hopes that in the future, systems can be developed to share information, with the patient's permission, regarding which supports they are currently accessing, and to facilitate and streamline referrals.

Highland Hospital – Using EHR to Protect Survivors

Highland Hospital prides itself in the precautions it takes to keep information about survivors of sexual assault, domestic violence, and sex trafficking protected. Through the work of Kio Pak, Program Coordinator of Highland's Sexual Assault Response and Recovery Team (SARRT), the program has obtained funding to provide a secure, confidential EHR that is separate from the hospital's mainstream EHR, which protects data stored there from being subpoenaed. This system allows extremely vulnerable patients, who may otherwise face criminalization and other legal issues, to feel safe to confide in staff. The SARRT advocates are then able to better support survivors of violence as they move towards making changes in their lives to improve medically, mentally, emotionally, and as a whole. This system is also how the team is able to conduct their data collection and analysis of the program.

EHR section of the report authored by Dr. Lela Bachrach and Dr. Susie Baldwin with contributions by Lacey Tauiliili, MPH, CHES.

Figure 1: UBCHO Epic SafetyNet Tool to Respond to Patients Impacted by Human Trafficking



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ICD-10-CM Coding for Human Trafficking

Introduction

Human trafficking is a public health concern many hospitals and health systems are combating every day. It is a crime occurring when a trafficker exploits an individual with force, fraud or coercion to make them perform commercial work or sex.

Data Collection Challenges

While more and more providers are trained to identify and document victims of forced (labor) or sexual exploitation, the existing ICD-10-CM abuse codes fell short of differentiating victims of human trafficking from other victims of abuse. Without proper codes, there was no way for clinicians to classify adequately a diagnosis and to plan for the resources necessary to provide appropriate treatment. This also prevented critical tracking of the incidence and/or reoccurrence of labor or sexual exploitation of individuals.

What's New

As urged by the AHA's Hospitals Against Violence initiative, the first ICD-10-CM codes for classifying human trafficking abuse were released in June 2018. AHA's Central Office on ICD-10, in partnership with Catholic Health Initiatives and Massachusetts General Hospital's Human Trafficking Initiative and Freedom Clinic, proposed the change. Effective FY 2019, unique ICD-10-CM codes are available for data collection on adult or child forced labor or sexual exploitation, either confirmed or suspected. These new codes, which drew support from other hospitals and health systems, may be assigned in addition to other existing ICD-10-CM codes for abuse, neglect and other maltreatment. In addition, new codes are also available for past history of labor or sexual exploitation, encounter for examination and observation of exploitation ruled out, and an external cause code to identify multiple, repeated, perpetrators of maltreatment and neglect.

Required Action

- As coding professionals review a patient's medical record to identify the appropriate ICD-10-CM codes to include, they should be aware of and begin utilizing the ICD-10-CM codes for forced labor and sexual exploitation, listed in Table 1.
- Hospitals and health systems should educate necessary individuals, including physicians, nurses, other health care providers, and coding professionals of the important need to collect data on forced labor or sexual exploitation of individuals.
- Tracking confirmed and suspected cases in the health care system will allow hospitals and health systems to better track victim needs and identify solutions to improve the health of their communities. It also provides another source for data collection to inform public policy and prevention efforts, as well as support the systemic development of an infrastructure for services and resources.

For additional information: Contact **Nelly Leon-Chisen**, RHIA, director of coding and classification, American Hospital Association, *nleon@aha.org*.

Key Terms

Key Terms Related to Human Trafficking Found in Medical Documentation

- Human trafficking
- Labor trafficking
- Sex trafficking
- Commercial sexual exploitation
- Forced commercial sexual exploitation
- Forced prostitution
- Forced sexual exploitation
- Forced labor exploitation
- Exploitation of manual labor
- Exploitation of sexual labor
- Exploitation for manual labor
- Exploitation for commercial sex
- Domestic servitude
- Labor exploitation for domestic work
- Force labor exploitation for domestic work

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Table 1
Human Trafficking ICD-10-CM Code Categories

ICD-10-CM Code/ Subcategory	Title
T74.51*	Adult forced sexual exploitation, confirmed
T74.52*	Child sexual exploitation, confirmed
T74.61*	Adult forced labor exploitation, confirmed
T74.62*	Child forced labor exploitation, confirmed
T76.51*	Adult forced sexual exploitation, suspected
T76.52*	Child sexual exploitation, suspected
T76.61*	Adult forced labor exploitation, suspected
T76.62*	Child forced labor exploitation, suspected
Y07.6	Multiple perpetrators of maltreatment and neglect
Z04.81	Encounter for examination and observation of victim following forced sexual exploitation
Z04.82	Encounter for examination and observation of victim following forced labor exploitation
Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z91.42	Personal history of forced labor or sexual exploitation

*Subcategories require additional characters for specific codes. Please refer to ICD-10-CM for complete codes

The AHA has also developed numerous tools and resources to help hospitals and health systems combat human trafficking in their communities.

For access to these resources, please visit *https://www.aha.org/combating-human-trafficking.*

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Use of Sexual Assault Response and Recovery Team: Highland Hospital's Unique Approach to Protocol Implementation for Sex Trafficking

To implement a sex trafficking response protocol at Highland Hospital, the Sexual Assault Response and Recovery Team (SARRT) leveraged their existing Rape Crisis Center (RCC). The SARRT program at Highland Hospital has been functioning as a State Funded RCC since 1994. As such, the SARRT program had already been servicing survivors of sex trafficking when they presented to the Emergency Department for sexual assault.

The SARRT program responds within 30 minutes (27/4, including holidays) to all sexual assaults and provides bedside advocacy. The team provides accompaniments for medical examinations, law enforcement interviews, sexual assault forensic exams, child protective services interviews, and court proceedings, and provides on-going follow up services. Follow up services include, but are not limited to, case management, counseling, housing support, and basic needs/resources. The program also operates a 24/7 crisis hotline. The program is funded through various grants and can also address problems around domestic violence. All services are free of charge.

All staff in the SARRT program is State Certified as sexual assault and domestic violence advocates and counselors. As such, they maintain a high level of privilege with regard to patient confidentiality; SARRT advocates do not document in patients' medical records. Additionally, advocates are trained in working with sex trafficking survivors. They are well versed in trauma-informed practices and utilize an empowerment framework when providing services. They are accustomed and skilled at working in multidisciplinary teams and are highly networked with community based organizations for referral services and the DA's victim witness program. Lastly, the program offers emergency shelter placement and housing support for survivors that are over 17 years old. They currently rent 7 beds from a local room and board that provides emergency shelter, meals, and clothing.

The sex trafficking response protocol at Highland was implemented by utilizing the existing SARRT program as the main point of contact for all patients who are identified or suspected of sex trafficking. Since the SARRT advocates are already trained in identifying risk factors, trauma informed practices and engagement, they focused on providing medical staff and employees with training on how to identify risk factors and how to make a direct referral to SARRT advocates. They first identified the training needs of medical providers and staff, finding that while many of the providers and staff were already aware of the existence of sex trafficking in Oakland, many were not confident about how to respond and engage with survivors. Based on the feedback from various providers, medical staff, and employees at all levels, trainings include information on prevalence, risk factors and red flags, but focus on trauma informed engagement and direct referral to the SARRT Advocate.

The team has implemented a mandatory audio/video sex trafficking training into the employee annual competency training requirements and additionally they facilitate voluntary, monthly in-person trainings.

As such, all Highland medical staff and employees are required to contact the SARRT advocate when they suspect a patient is at-risk or being sex trafficked. The SARRT advocates respond within 30 minutes/24 hours a day, 365 days a year.

Authored by Lacey Tauiliili of Highland Hospital Sexual Assault Response & Recovery Team

Editor's Note: Due to funding restrictions, Highland's SARRT advocates currently do not provide any services to survivors of labor trafficking unless they report sexual assault, so the hospital's protocol does not yet incorporate a response for these survivors.

Project Survey Results and Reflections from Organization Partners, Hospital Teams, and Community Based Organizations

Feedback from Hospital Teams
Survey Results

To understand the perspectives of the 4 hospital teams who participated in the protocol development and implementation process, HEAL Trafficking circulated a mixed methods survey, collecting quantitative and qualitative feedback from participants. The surveys were designed on the Survey Gizmo platform and distributed electronically; responses were anonymous, though hospital names were collected from the health care providers. Data were collected between February 15 and March 1, 2019.

Response Rates

The initial email containing the survey link was sent to 67 people on the H.E.A.T. Institute's list of hospital contacts, of which 13 addresses bounced, for a total of 54 surveys delivered. It is unknown how many of these recipients opened the email containing the survey link. In addition, the survey was further circulated internally at Children's Hospital, so the total number of people invited to participate is not known.

Seventeen people opened the survey, a rate of 31.5%. However, 8 of these did not complete the survey, with most of these 8 not answering any questions at all; this represents a survey completion rate of 52.9%. When available, the responses entered for the partial surveys are included in the results.

The total number of completed surveys equals 9. Of the 34 hospital champions and team members identified by name by HEAL Trafficking consultants as regular participants in protocol, this gives a completed survey response rate of 26.5%. However, because the survey responses were anonymous, we do not know which of the regular participants actually completed the survey vs. other hospital personnel who were more peripherally involved.

Key Findings

The process for protocol development in the pilot project was designed to occur through team meetings, some with the HEAL Trafficking consultant and H.E.A.T. Institute present to offer guidance and support. The number of meetings survey respondents attended varied greatly, with 23% attending only 1-2 meetings through the course of the project and 8% meeting over 15 times.

Only 15% of participants reported that they had protected time to work on the project. (Protected time means that participation was part of their job responsibilities for which they were allotted work hours, outside of clinical care, administrative tasks, and other assignments.) Over three quarters of all respondents, 77%, expressed the sentiment that protected time was very important. While 54% expressed feeling very supported by their manger, 31% felt somewhat supported and 15% said they were supported but very little. Less support was felt by participants from hospital administration.

Participants were asked how helpful the HEAL Trafficking Protocol Toolkit was in planning their protocols. 58% of participants found it very helpful, 25% found it somewhat helpful, and 17% reported that they did not use the Toolkit as a guide. The most helpful part of the toolkit in developing various hospital's response protocols was the Getting Started section with 50% of participants indicating that section as helpful. Engaging partners, Protocol Components, and Moving Forward sections were viewed as helpful by 41.7% of participants.

Feedback for improving the toolkit included the need for a list of common terminology used by trafficking victims. Participants also suggested we add sections on implementation in the ED, discussion of new ICD-10 codes, how to sustain the work, and how to contact more Community Based Organizations (CBOs). One respondent expressed interested in using the Toolkit further with school based health clinics.

The survey assessed satisfaction with the HEAL Trafficking consultants. 42% of participants were very satisfied with their consultants while 25% were satisfied, 25% were neutral, and 8% were very dissatisfied. Notably, some of the hospitals did not schedule meetings with their consultants, as was outlined in expectations for the project, which challenged the consultants' ability to offer support and guidance.

Most participants found the Regional Learning Exchange meetings useful. On a scale of 0 (total waste of time) to 100 (fascinating, stimulating, useful meeting), the overall experience at the meetings was rated at a mean of 73.4 and a median of 77, with responses ranging from 50-91. Positive feedback about the meetings included that it was useful to learn from other health systems and foster collaboration, there was a good range of protocols, and that the meetings and insight provide a lot of information. Negative feedback on the meetings included that some people dominated the conversation and partners could not agree on the path forward as they were in different stages of development. One participant was unsure if the ideas could be replicated outside of the county system, but because only one hospital in the pilot project was a county hospital, it is difficult to interpret the meaning of this comment.

Over one third, 36% of respondents, strongly agreed "that the Regional Learning Exchange process moved our region closer to a regionalized health system response to human trafficking. " Almost half, 46%, somewhat agreed with this statement, and 18% were neutral. The group did decide to continue the Regional Learning Exchange meetings on a quarterly basis, indicating that while there is room for improvement, participants appreciated the opportunity to come together to discuss issues.

Hospital personnel's perception of the overall outcomes of the protocol development project indicates that the project was a success. 63.6% of participants said the process increased their knowledge about important factors to consider in caring for patients potentially impacted by trafficking a lot. 63.3% of participants also felt that their comfort in guiding colleagues thorough the process of engaging with patients impacted by trafficking increased a lot, with 36.4% saying they had a little increase in comfort and zero

participants saying they had 0% increase in comfort. 63.3% of participants felt their hospital's preparedness to assess and interview potentially trafficked patients in a trauma informed manner increased a lot. While only 27.3% of participants stated the process improved "a lot" their familiarity with CBO's to which they can refer patients, 63.6% said their familiarity improved a little bit. Clearly, more work remains to be done in improving hospitals' relationships with CBOs who can provide services for trafficking survivors.

The overall success in trafficking protocol creation was assessed, with 64% feeling very successful or somewhat successful. Successes shared include starting implementation in the ED, and starting to educate ED physicians and nurses. Other participants were successful in creating ongoing engagement of a multi-disciplinary team, implementation of the Epic SafetyNet tool, incorporation of a trafficking educational curriculum for residents, and increased ability to justify securing emergency housing for trafficked patients. Participants indicated that some of the remaining challenges include carrying out implementation in the ED, having protected time to work on the project, getting leadership engaged, having bedside advocates for patients, the fragmented nature of community services, lack of a streamlined process, lack of follow-up with providers, and difficulty prioritizing the next steps in development and implementation of the protocol. The need for protected time to do this work was once again highly emphasized. Most people who responded felt that patients and staff had benefited from the protocol work so far but two individuals did not report any benefit.

Moving forward, most hospitals will need to develop data tracking systems and implement quality assurance processes for the protocol. Multiple participants indicated that implementing their protocol remains a challenge. Two thirds of participants indicated that their hospital will continue working on its human trafficking response protocol.

Feedback from Community Based Organization Survey Results

To understand the perspectives of the community based organizations (CBO's) who participated in the protocol development and implementation process, HEAL Trafficking circulated a mixed methods survey, collecting quantitative and qualitative feedback from participants. Data were collected in early March, 2019.

Response Rates

The initial email containing the survey link was sent to 21 people on the H.E.A.T. Institute's list of community contacts, of which 2 addresses bounced, for a total of 19 surveys delivered. It is unknown how many of these recipients opened the email containing the survey link. It is also not known how many of the individuals in this list attended one or more hospital kick off or Regional Learning Exchange meetings.

Eight people opened the survey. However, 5 of these did not complete the survey, not answering any questions at all. The total number of completed surveys equals 3. Of 11 CBOs who participated in some aspect of the project, this gives a completed survey response rate of 27.3%. Considering all the CBOs to whom the survey was sent, the response rate is 14.2%.

Key Findings

The poor survey response from the CBO's is a measure in itself, with fewer than a third of the agencies who participated in the project responding to the online questionnaire. There may be multiple reasons for this, including competing priorities, not feeling engaged enough in the process to evaluate it, missing the emails inviting survey participation, etc.

Three organizations had been involved with the protocol development project for an average of 17 months, while the respondents had been personally involved for 10 months. Attendance at the Regional Learning Exchanges varied, with 66.7% attending both the Highland Hospital Kick off in May 2017 and the meeting at the Alameda Family justice center in June 2018. No organizations attended the October 2018 meeting and only one attended the December 2018. Nonetheless, these respondents generally viewed the meetings as useful, rating the overall experience with a mean of 74 (on a scale of 0-100, 0 being a waste of time and 100 being fascinating stimulating and useful), and a range of 53-85.

The 3 organizations disagreed in their opinions of whether the Regional Learning Exchange process move the region closer to a regionalized health system response to human trafficking, with one third (33%) indicating they strongly agreed that it did, 33% strongly disagreeing, and 33% neutral. Two thirds of organizations said the protocol development increased "a lot" their connections to health care providers who can refer their patients to the organization, 33.3% said a little and 0% said not at all. 33% of organizations indicated they increased collaboration with local health care providers a lot, and 66.7% a little.

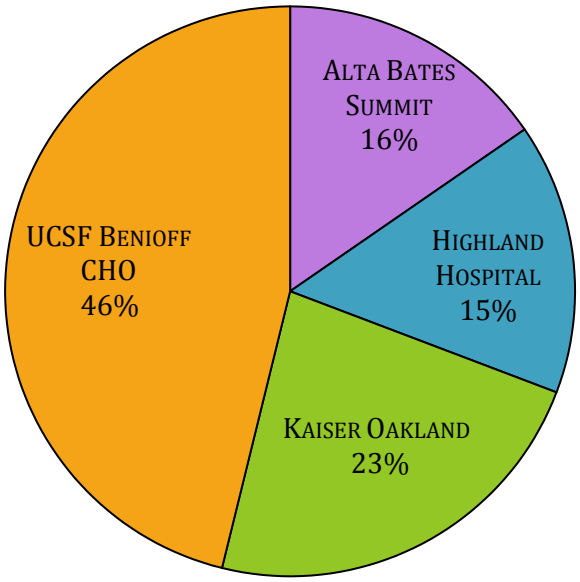
Collaboration between local health care providers and CBOs can definitely be improved. Organizations indicated that barriers to partnering with hospitals include lack of understanding about labor trafficking, inability to identify labor trafficking red flags, and lack of resources to offer to trafficked patients. There is also a need to improve the process of connecting patients to the resources that do exist. Furthermore, uniformed staff may re-traumatize patients. Organizations indicated that their most valuable success is increased networking with the surrounding hospitals.

All feedback survey results, including quantitative and qualitative responses, are available in Appendix 1.

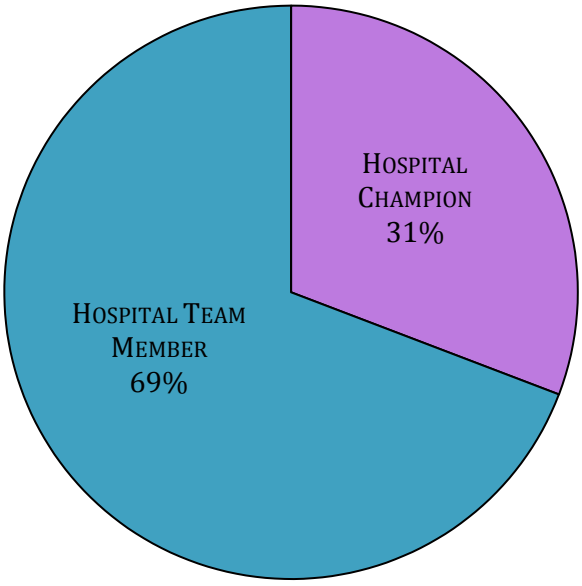
Hospital Champions and Teams

Information on Respondents

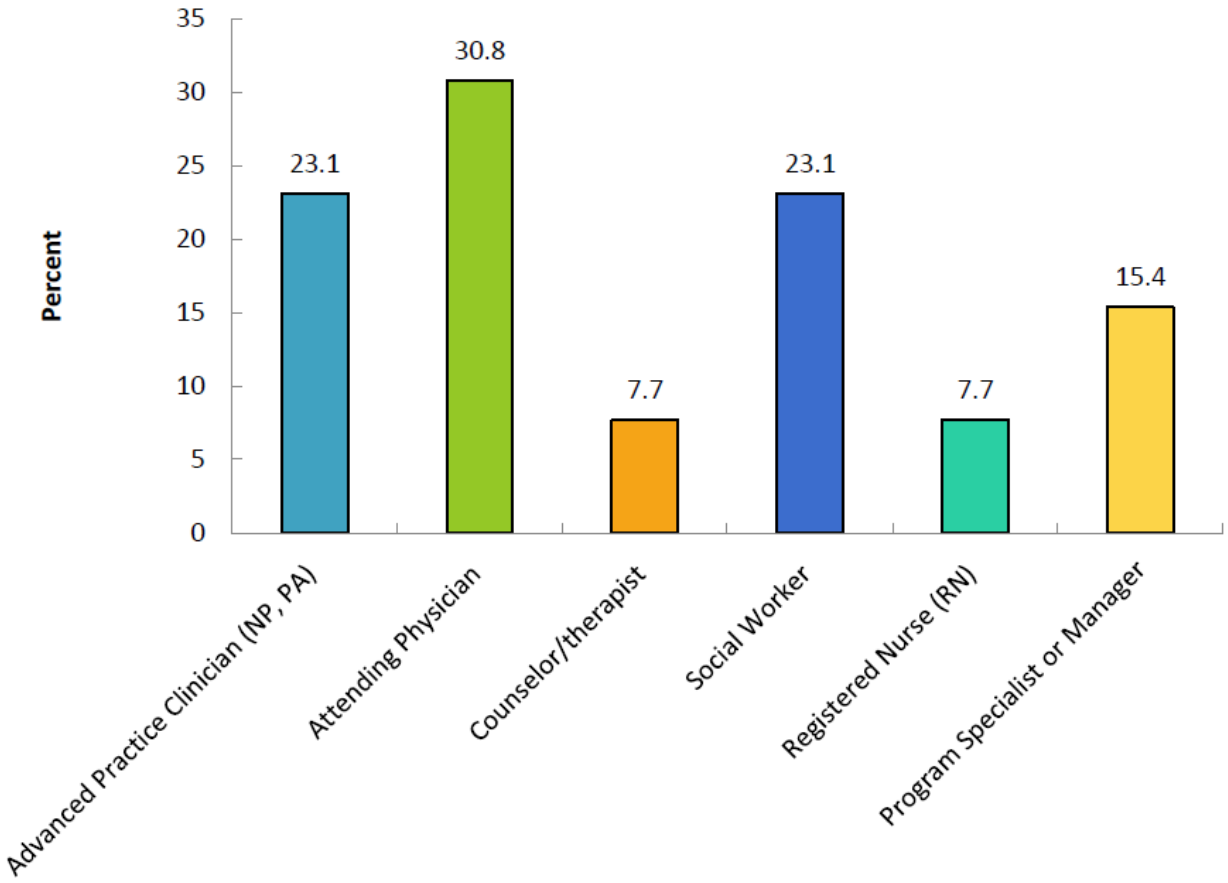
Which hospital system are you affiliated with?



What has been your role in the H.E.A.T. Institute - HEAL Trafficking Human Trafficking Protocol Development project?



What is your professional role? Check all that apply. Please specify "other" if you play a role not listed.



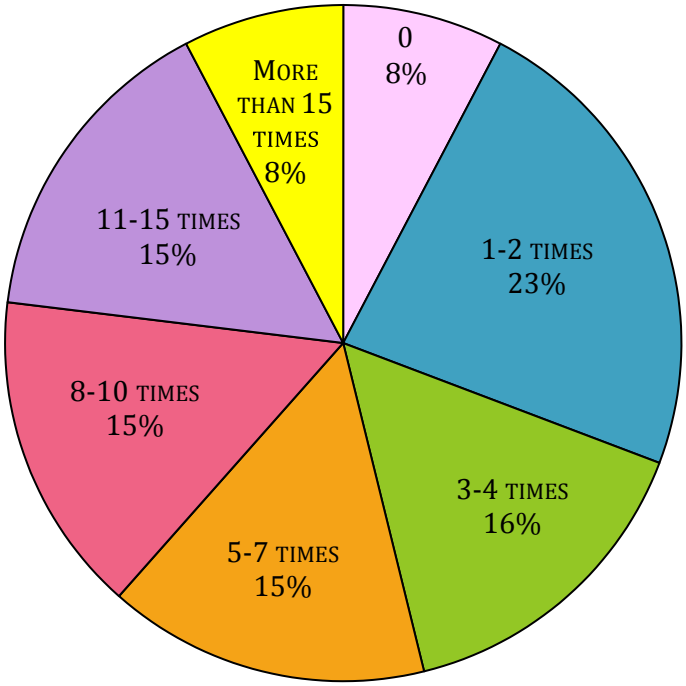
For approximately how many months have you worked/did you work on the Human Trafficking Protocol Development project?

Notes: The project officially kicked off on May 23, 2017, but work preceded that meeting. One respondent indicated that they were not actively involved in the process, and their response was removed. One person responded, “at least 12 months,” and they were coded as 13 months.

Range: 1 month – 24 months
Mean (average): 9.8
Median: 10.0

The Process

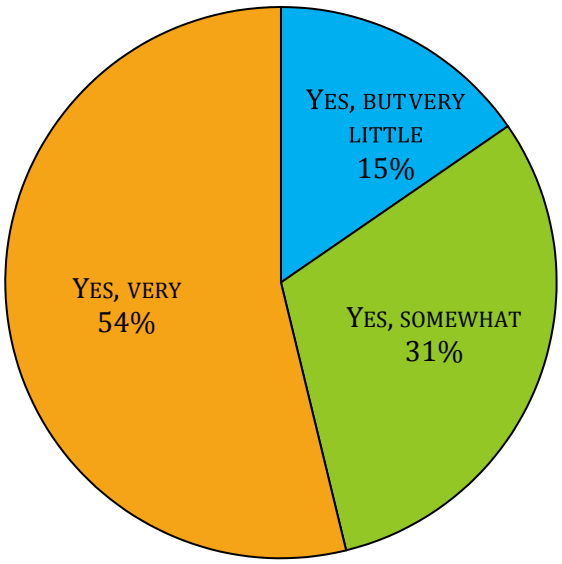
How many times did you meet with your colleagues INTERNALLY about protocol development or implementation, with or without HEAL Trafficking or H.E.A.T. Institute personnel present?



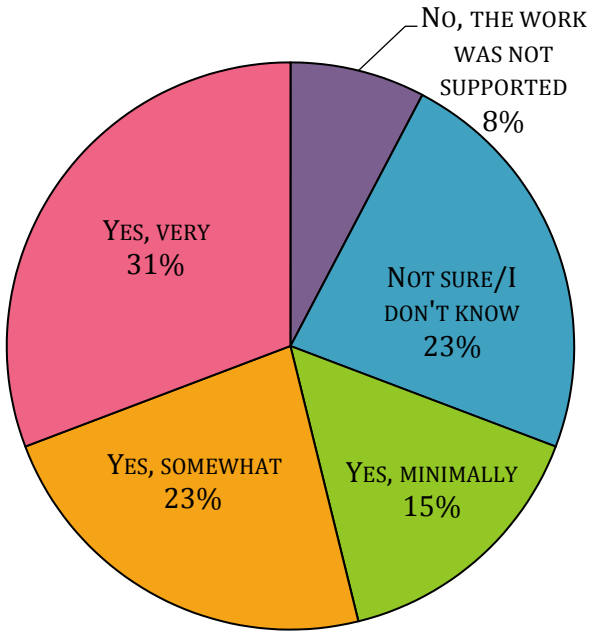
Comments:

We had our usual monthly anti-trafficking meetings as well as a bunch of special meetings outreaching to new groups of health team members (perioperative services, office associates, school-based health, etc.)
we definitely need to meet more often
I am not actively involved but am kept informed via email.

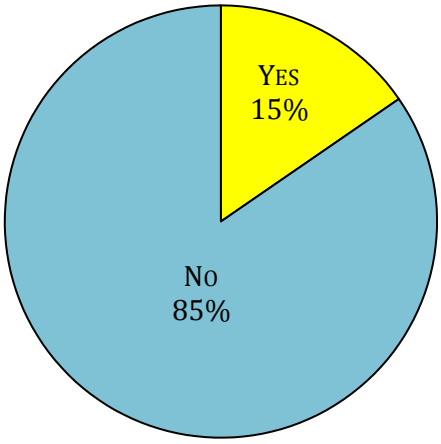
Did you feel supported by your supervisor/manager to spend time on this project?



Did you feel supported by the hospital/administration in this work?



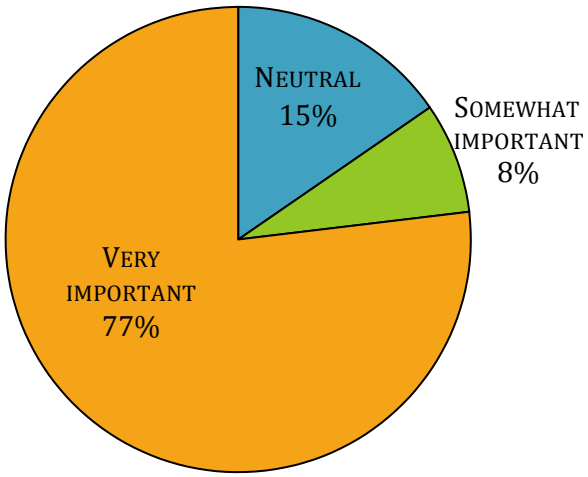
Did you have protected time to work on this project? That is, were you allowed to suspend other duties for a certain number of hours each week or month to work on developing a response for patients potentially impacted by human trafficking?



Comments

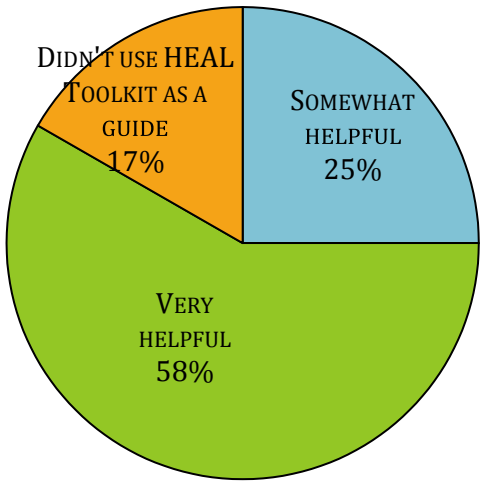
1 hour a month
As needed, Human Trafficking is part of my role.

In your opinion, how important is protected time to the development and implementation of trauma informed protocols to guide interactions for patients impacted by trafficking and other forms of violence?

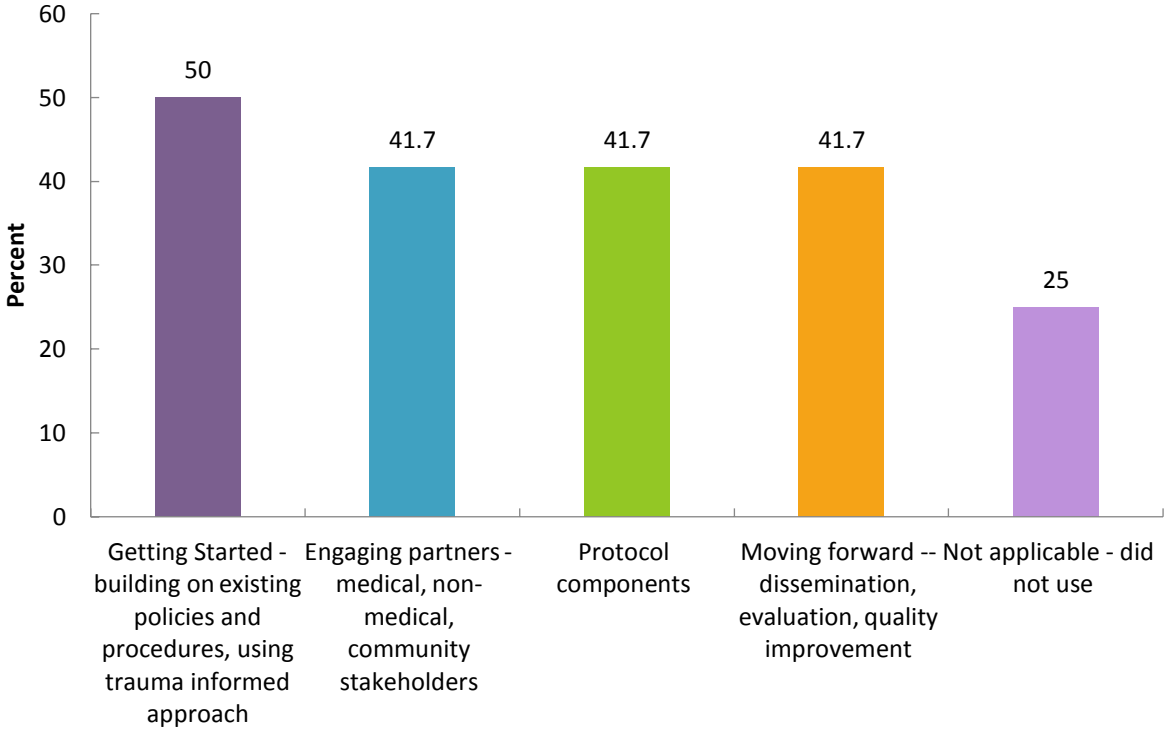


The HEAL Trafficking Protocol Toolkit

In planning your protocol, how helpful was the HEAL Trafficking/Hope for Justice Protocol Toolkit for Developing a Response to Human Trafficking Victims in Health Care Settings?



Please check the sections of the HEAL Protocol Toolkit that were helpful to you in developing your hospital's response protocol.

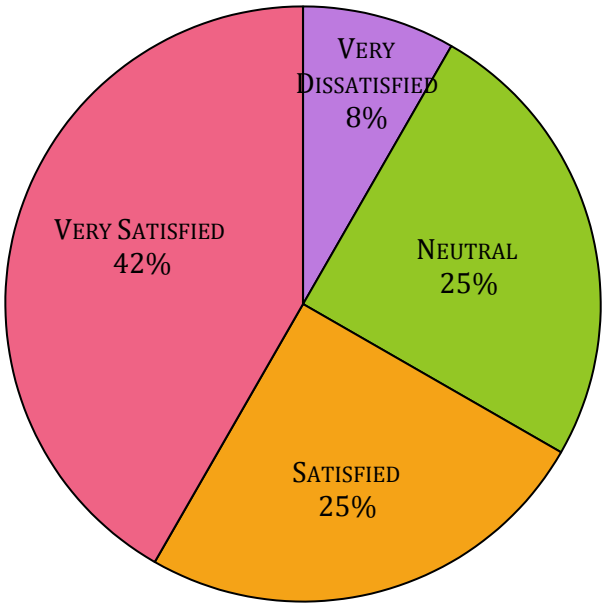


We will be revising and updating the HEAL Toolkit. What feedback do you have for future versions of the HEAL Toolkit, including what was most useful, and things that should be added to or deleted from the document?

Comments:

implementation in the ED
Discussion of new ICD-10 codes and best practices related to these, electronic health records, protecting patient confidentiality, and information sharing. Also, might be great to have more info regarding how various health systems sustain their trauma-informed work on violence, abuse, HT, etc.
more CBO's that can be contacted and respond to the hospital
Right now I am not sure, but I would like to have this toolkit discussed with the school-based health clinics.
Easy to use guides and steps were very helpful.
It was very helpful.
As a medical professional part 3 of the toolkit, the process of identifying patients at risk, guidelines and strategies for interviewing patients at risk for trafficking. In addition to our team meeting with Carla Dartis who provided a list of common terminology used by victims of trafficking that is helpful during the interview process in the hospital, otherwise their language could be viewed as just street oppose to clues. I believe that list should also be part of the toolkit

How satisfied were you with the guidance or assistance provided by your HEAL Trafficking consultant on this project?

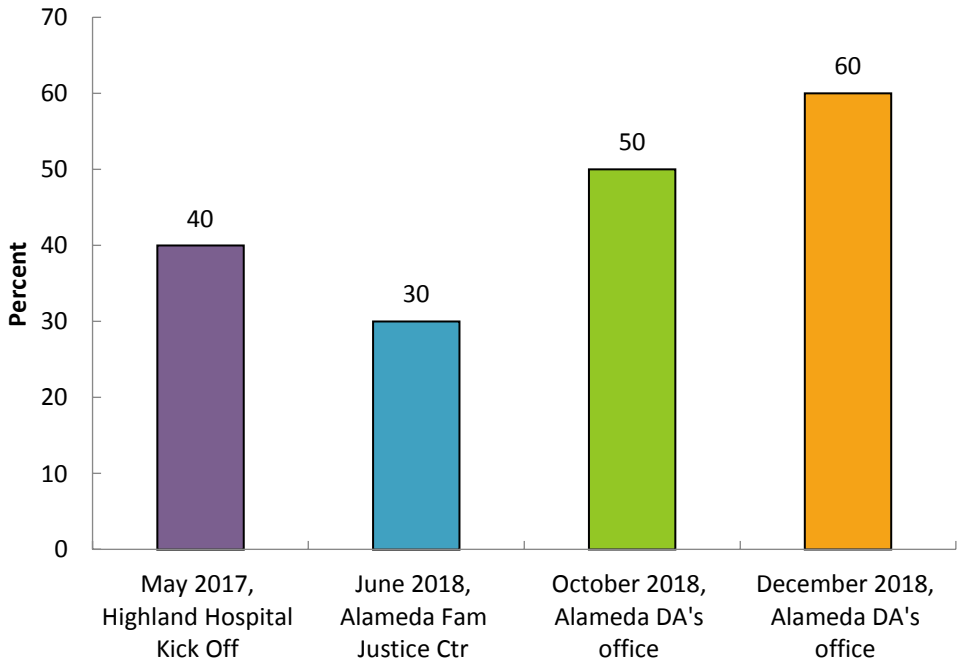


Comments

I worked as an ED doctor to help with implementation
It was very convenient to be wearing both hats (champion and consultant). It was wonderful to have the input from the other HEAL Trafficking consultants on issues that came up.
Great to have consultants in the meeting as a resource
I am not sure who this consultant is, so I can't adequately respond.
I did not meet with the HEAL Trafficking consultant
I joined late in this project, my role was minimal in the engagement and collaboration piece.
Very on top of this work!

Regional Learning Exchange Meetings

Which Regional Learning Exchange meetings did you attend? Check all that apply.



On a scale of 0-100, where 0 = a total waste of your time and energy and 100 = a fascinating, stimulating, useful meeting, how would you rate your overall experience at the Regional Learning Exchange Meetings?

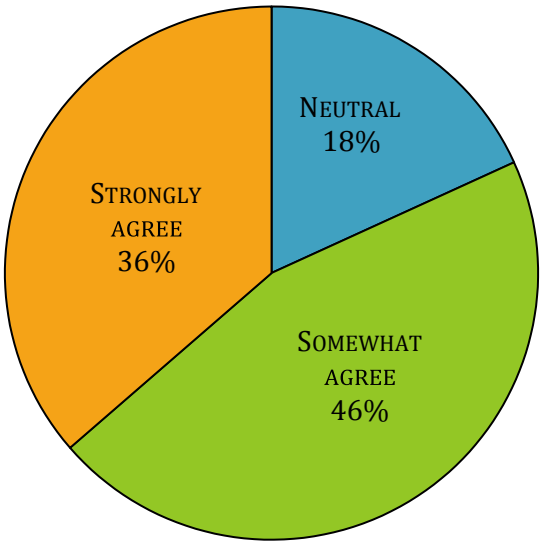
Range: 50-91
Mean (average): 73.4
Median: 77

Please comment on what you liked and disliked about the Regional Learning Exchange meetings.

It was wonderful to learn how other health systems were approaching their response protocols and to hear about practices we could try to adopt in our system. Also, meeting the individuals working on HT at other hospitals lead to more engagement and collaboration,
Some people dominate the discussion with their opinions (that are not necessarily the opinions of all).

Seems very county oriented, not able to mimic outside of county programs.
Partners at different stages of development and not always in agreement for the path forward.
Liked: The range of protocols Dislike: the length of time the policies take to be implemented.
Good to have everyone at the table.
The meetings are always insightful and provide a lot of information. In the hospital setting, i believe we need more collaboration with our Police Departments and their task force. How to build more personal relationships with our community partners to get identified victims the safety resources. Age limits make it harder provide services, and I am aware this is a road block always being addressed.

Do you agree that the Regional Learning Exchange process moved our region closer to a regionalized health system response to human trafficking?

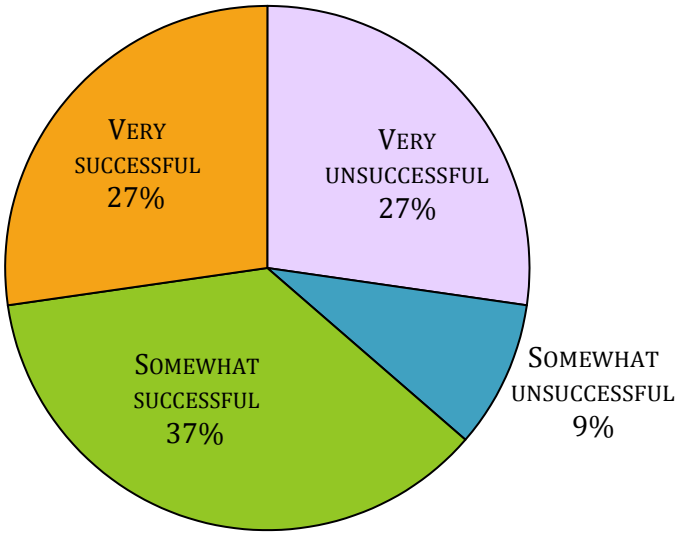


Outcomes

Did the human trafficking response protocol development process...

	No	Yes, a little	Yes, a lot
Increase your knowledge about important factors to consider when caring for patients potentially impacted by trafficking?	18.2%	18.2%	63.6%
Increase your comfort in guiding colleagues through the process of engaging with patients potentially impacted by trafficking?	0%	36.4%	63.6%
Increase your comfort in responding to patients whom you suspect are trafficked, but who do not disclose and/or who decline assistance?	18.2%	18.2%	63.6%
Improve your hospital's preparedness to assess and interview potentially trafficked patients in a trauma informed manner?	27.3%	9.1%	63.6%
Improve your familiarity with community based organizations where you can refer patients for support?	9.1%	63.6%	27.3%
Increase the hospital's collaboration with community organizations?	27.3%	27.3%	45.5%
Cause you to give more consideration to labor trafficking victims and survivors in your community?	9.1%	45.5%	45.5%

In your opinion, how successful were your team's efforts in creating a protocol that guides hospital staff through provision of a trauma informed response to patients potentially impacted by human trafficking?



Please list 1 - 4 successes achieved

- starting an implementation in the ED
- educating ED docs in human trafficking
- educating nurses

- Ongoing engagement of a multi-disciplinary team (adol med, Center for the Vulnerable Child (CVC), Center for Child Protection, school-based health centers, mental health/behave health integration/dept of psych, emergency department, pediatric primary care clinic, perioperative team, social work, office associates and nursing education leadership)
- Went live with updated Epic SafetyNet tool on 12/19/2018—this will facilitate identification, trauma-informed information sharing, referrals and data collection.
- Have human trafficking education curriculum embedded in community and advocacy rotation in progress for all UBCHO residents
- Learning exchange between institutions (hospital champions from HGH and KO came to meet with me re: UBCHO Epic tools; I learned about KO's DV program and HGH's bedside advocate program, etc.)

- The development of a protocol at all
- A multi-disciplinary collaboration between pediatrics, ED and adolescent medicine

- Response protocol for the ED
- Cross training advocates to cover HT in the ED 24/7
- Justifying securing emergency housing

- We have been trained

- Within electronic medical records we have assessment and protocol tools easily available.

- Our current protocols had already included trauma informed responses, we incorporated more training around human trafficking survivors.

- We have created a protocol for our hospital for human trafficking and are now working on creating in service education trainings to our department to increase knowledge, and find out what our staff need our to feel more comfortable moving forward with this work

Please describe 1-4 challenges you and your team faced in the process of developing your protocol.

- actual implementation process in the ED
- getting the CM/SW to have protected time to help with this project

- UBCHO leadership not fully engaged in this process
- No real bedside advocate 24/7 response at our institution the way HGH does
- Hospital champions with no protected time to do this work
- Fragmented services in the community
- Would love a streamlined process to access support for patients, such as call one number and they will leverage all the relevant agencies potentially similar to in SF (and with services for transitional age youth)

- Time to develop the protocol and collaborate in a meaningful way (meaning, developing something more fully completed)

• No good pathway for implementation outside of the local KP East Bay area (ie Regionally)
• Not a county program
• Identify needs for better response from CPS • Follow up for providers
• Having regular meetings and protected time to work on the project
• Working with our EMR people takes a long time.
• Clarity of the steps to be taken.
• Breaking down the information, determining what's most important to start with when so much information is provided.

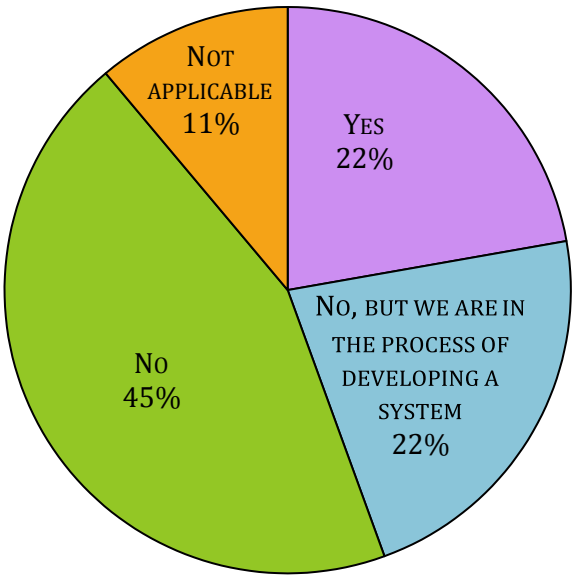
Do you think that any patients or staff have benefited from your protocol work so far? If so, please describe.

Purely from educating the ED MDs and Nurses.
Yes. We are working more closely with the ED now and there have been more patients offered support. Also, prior to this process, we weren't aware about some of the community groups that support transitional age youth such as Progressive Transitions.
Yes - improved awareness, referrals, and recognition
no
Yes, patients have definitely had improved response.

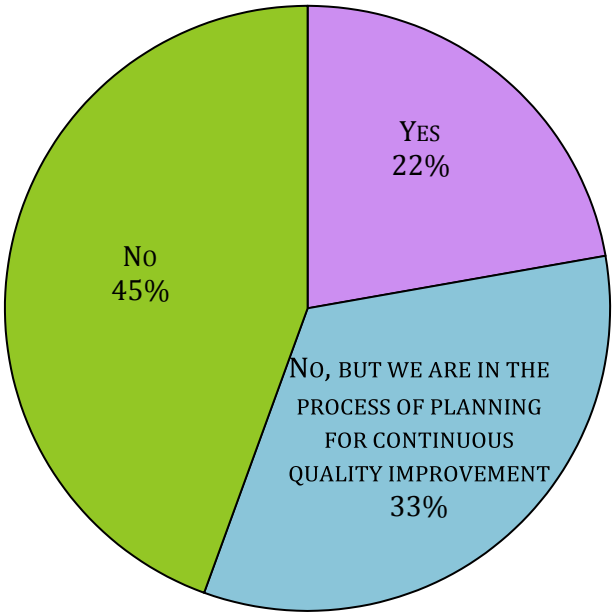
no
I hope so -- still training folk on how to use it.
Yes, our medical staff reach out to our team for support where in the past they may not have.
Yes, at this time our champions have been called upon when a potential victim is identified, work assignments can be adjusted to allow that individual to provided the right information and advocacy to the patient. Our goal id to have everyone educated and informed.

Moving Forward

Have you developed a data tracking system to document and track encounters that involve a patient who is a suspected or confirmed victim of labor or sex trafficking?



Have you developed a process of case review or team debriefing to assess the pros and cons of the protocol and make adjustments and improvements?

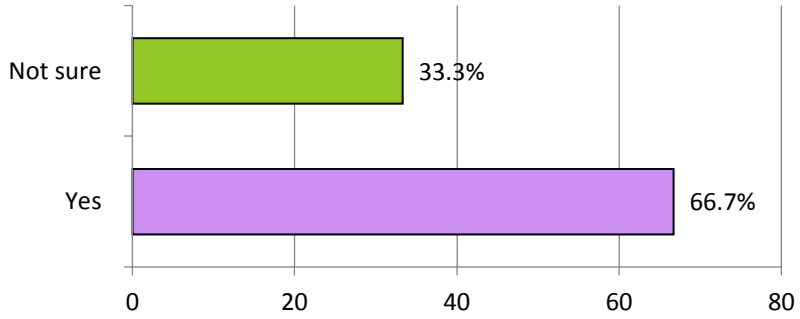


Please describe remaining gaps or challenges your team faces in developing and/or implementing a human trafficking response protocol.

actual implementation
Hoping that an internal grant will go through to sustain the momentum that this project kicked off. With that small amount of institutional support, I think we can make a lot of progress. Our EHR will soon merge with main UCSF EHR. Hope our anti-trafficking tools will be available to a broader audience once this occurs rather than getting cut.
• Completing the protocol with everyone's input • Implementing it • Data collection, tracking, maintaining it and spreading it outside of our local area
not started
• Need better CPS response • Need clear mandate for reporting vs referring HT

regular meetings, protected time to work on the project and have meetings
Hospital wide training
More shelters and resources
Its time to fully implement our fina protocol. Holiday time caused a gap in meetings and committee participation. With the new year starting we're getting back on track

Do you think that your hospital will continue its work in developing, implementing, and improving its human trafficking response protocol?



What are your hospital's next steps for the work of developing, implementing, and improving your human trafficking response protocol?

Applied for internal grant as above. If that goes through, hope to be able to apply for external grants to sustain the work. Goals include: ensuring that all UBCHO faculty, staff, and trainees have regular access to trainings to raise aware about all forms of human trafficking, how it impacts patients, and how to respond. We plan to embed a human trafficking curriculum module in the residents Community Advocacy Primary Care rotation. We are continuing our project to get input from survivors of human trafficking regarding our Epic SafetyNet tool and our anti-trafficking education efforts. Soon our Epic SafetyNet tool will be able to generate regular data reports. Also, hope to have a dedicated case manager working on linkage to care and support for these patients.
1. complete the protocol 2. involve more stakeholders 3. pilot in Oakland/East Bay 4. Roll out to other sites

Continue training and tracking identified patient through the medical system.
training
Ensure the utilization of protocols continues throughout our organization. Continue using tracking system.
In service training to the staff

Please share any other thoughts, experiences, praise, or constructive criticism about the project or process.

Thank you for this wonderful collaboration. Certainly gave us a needed boost to take our anti-trafficking work to the next level. The relationships that the project fostered with colleagues at other institutions will be very helpful going forward!
This is amazing work. It is a good first step. Recommend ongoing meetings (twice yearly) to discuss challenges, support implementation and continue growing.
not a county program
Appreciated the multidisciplinary approach.
so glad it is finally happening!

Community Based Organizations

Information on Respondents

What is the name of your organization?

Because of the small number of respondents, we cannot report the answers to this question.

For approximately how many months has your ORGANIZATION been involved with the H.E.A.T. Institute Hospital Human Trafficking Protocol Development project?

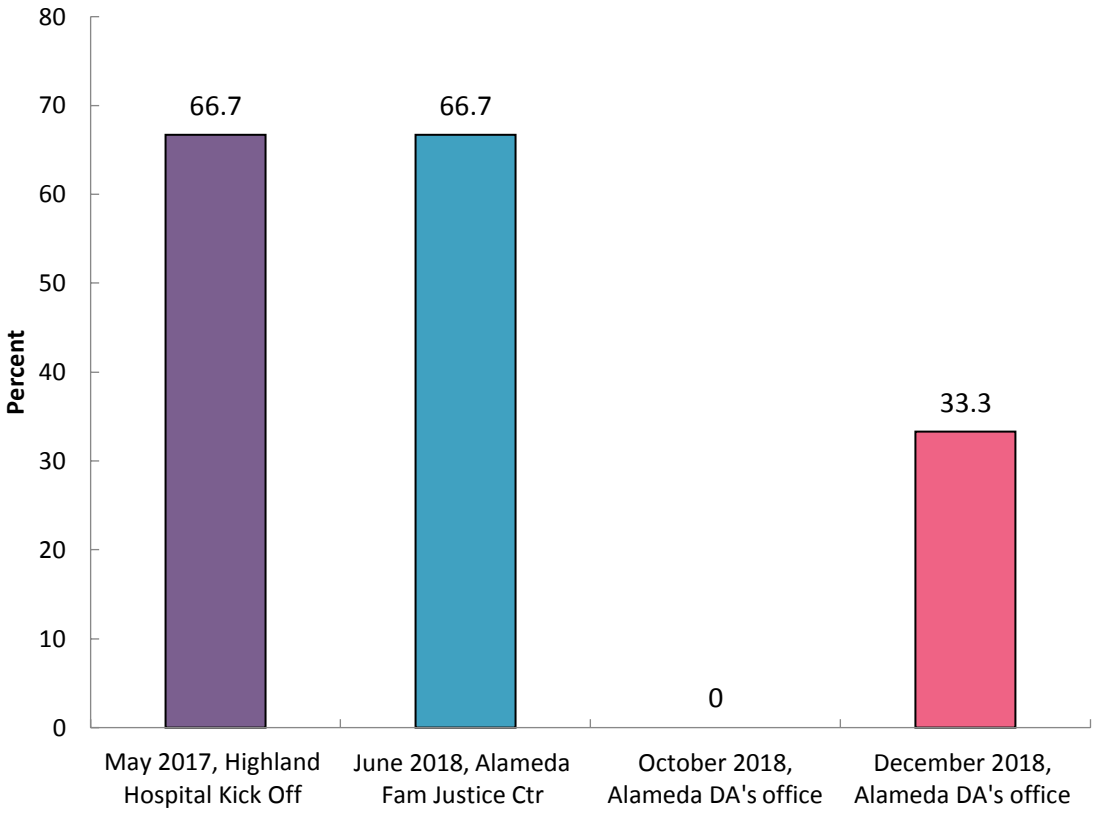
- **Range: 12 to "when the project began" (estimated at 21 months)**
- **Mean (average): 17 months**
- **Median: 18 months**

For approximately how many months have YOU personally been involved with the H.E.A.T. Institute Hospital Human Trafficking Protocol Development project?

- **Range: 0 -18 months (one respondent said they had not been involved at all)**
- **Mean (average): 10 months**
- **Median: 12 months**

Regional Learning Exchange Meetings

Which Regional Learning Exchange or other hospital protocol meetings did you attend? Check all that apply.



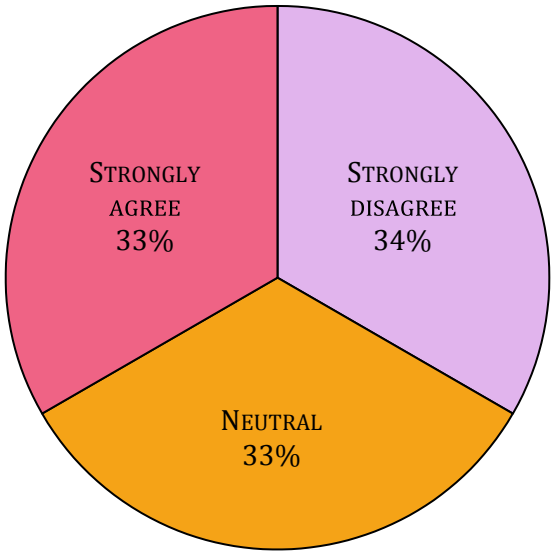
On a scale of 0-100, where 0 = a total waste of your time and energy and 100 = a fascinating, stimulating, useful meeting, how would you rate your overall experience at the Regional Learning Exchange Meetings?

- **Range: 53-85**
- **Mean (average): 74**
- **Median: 84**

Please comment on what you liked and disliked about the Regional Learning Exchange meetings.

Health care & CBOs working together specifically to discuss HT (sex and labor) protocols and being more aware within a clinical setting
I appreciated the detail of the conversation and the over all approach.
I only attended the kick off meeting and I sent my partner to the meeting at Kaiser in July both were good

Do you agree that the Regional Learning Exchange process moved our region closer to a regionalized health system response to human trafficking?



Outcomes

Did the human trafficking response protocol development process…

	No	Yes, a little	Yes, a lot
Increase your connections to health care providers who can refer their patients to you?	0%	33.3%	66.7%
Increase collaboration with local health care providers?	0%	66.7%	33.3%

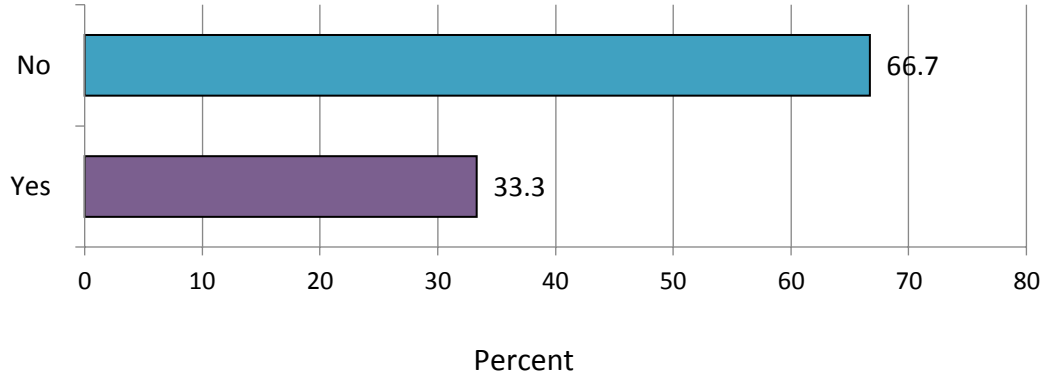
Please describe any challenges you have identified in partnering with hospitals to serve survivors of human trafficking. (Please enter N/A if not applicable).

There continues to be a lack of training/awareness/understanding of Labor HT cases, red flags, and resources. There is still more to be done to connect health services, benefits access (Medical) and undocumented HT clients.
Historically uninformed staff created barriers to communication/barriers and re-traumatization of the client.
My organization is not a first responder so I have not had any challenges

Please describe any successes or progress your organization has made in partnering with hospitals to serve survivors of human trafficking. (Please enter N/A if not applicable).

Connecting to local Health providers that belong to the most utilized Hospitals in the area, which opens the door to networking and creating not just protocols, but also increased HT training opportunities for health personnel.
We have a strong relationship with Children's Hospital and work well with Highland.
N/A

Have you received any referrals from health care providers/hospitals you've connected with through this H.E.A.T. Institute pilot project?



If you've received referrals, how many?

1	66.7%
2	0
3	0
4-5	0
6 or more	33.3%

Moving Forward

Please describe remaining gaps or challenges your organization faces in continuing to collaborate with health care providers in serving survivors of human trafficking.

More established connections with direct personnel at Hospitals, knowing which clients are being seen at which Hospital to help provide a HOLISTIC care plan, and guidance of how to connect HT clients with financial services support to PAY for these clinical visits. Many HT clients for already under-served communities do not know about Medical insurance benefits they are eligible for, and Hospitals don't red flag them as HT victims, which means clients are not referred to appropriate HT resources AND are not [provided] assistance with MediCal benefits to help pay for health costs. So we need to work together to help bridge that knowledge gap of helping clients to PAY for these services, based on their HT status.
Staff training across the board has improved but needs depth
N/A

Overall Project Reflections

The Importance of Trauma-Informed Care

Training health care providers about human trafficking is a fundamental step for the development and implementation of human trafficking response protocols in clinical settings. However, training on trauma informed service delivery is equally fundamental to the process of providing victim- or patient-centered care. As is the case with education around human trafficking, few doctors and nurses have ever received training on trauma informed care, and until the last few years most were not even familiar with the concept. A trauma informed health care system adopts—at every level of administration and clinical care— principles and practices that promotes a culture of safety, empowerment, and healing. Trauma informed care includes 4 key elements *(source: Substance Abuse Mental Health Services Administration of U.S. Department Health)*:

1. Realizing the prevalence of trauma;
2. Recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce;
3. Responding by putting this knowledge into practice; and
4. Resisting re-traumatization.

As Carla Dartis of the H.E.A.T. Institute notes in her insights about the overall project, "Health care must evolve and embrace the practices that create and sustain a trauma-informed culture." For example:

- Effectively responding to Human Trafficking requires health care team members to develop competency in implementing trauma informed care, which can be a major culture shift for organizations that are new to trauma informed principles and implementation. Of the four participating hospitals, Children's Hospital of Oakland, Kaiser Permanente Oakland Medical Center and Highland General Hospital realized this, and identified and integrated training into their process. Trainings were often arranged by Carla Dartis with support from community based trainers and subject matter experts. While these trainings added to the timeline needed for protocol development, they provided key personnel the foundation from which to do this work.
- The trauma-informed culture shift must be aided by the buy-in and actively engaged support of leadership in nursing, administrative and security personnel, mental health providers and physicians, and invested authority in line staff to design and implement procedures and protocols and take advantage of training opportunities.
- Critical to trauma-informed policies is enabling input of survivors and practitioners that work directly with survivors into the practices and policies. The trainings conducted by the HEAT Institute have routinely incorporated Survivor's voice, research and tools survivors have considered relevant. HEAL

Trafficking's final report was be reviewed by survivors, as was the HEAL Protocol Toolkit. The process of protocol development and implementation must be afforded sufficient time to insure input and review by survivors.

Continuous connections between government agencies, community based service providers, and hospital or clinic staff are essential for responding to patients who may be trafficked.

Physicians are trained to fix problems, but aside from providing needed medical services, medical personnel alone cannot meet the needs that trafficked patients present with. The first section of the HEAL Trafficking Protocol Toolkit for Developing a Response to Human Trafficking Victims in Health Care Settings outlines the myriad government, community, and academic organizations that can provide support for human trafficking victims identified in medical settings. Relationship building and maintenance with these agencies and organizations enable safe and efficient referrals for patients who are willing to accept assistance. Because most social service providers struggle to identify the resources to care for their clients, identifying sources of financial support for these organizations is key; nonprofit organizations should be compensated for the time their staff spend educating health care teams about their services. In the context of the H.E.A.T. Institute – HEAL Trafficking pilot project, Carla Dartis dedicated her time and energy to bringing community based organizations to the table and building relationships between them and the hospital teams. In the absence of a dedicated coordinator like Ms. Dartis, it is unlikely that the hospitals would have been able to meet and build relationships with the very agencies so critical to their success.

Carla Dartis notes,

- A big takeaway in the pilot effort was making connections between medical personnel and community providers that could fill service gaps to support patients suspected, at risk, and even confirmed victims of human trafficking. Leveraging training opportunities within medical settings or community forums that are held by social services and other public agencies could help build these connections.

- However, staff-turnover and fluctuations in the capacity of community based service providers create challenges for relationship continuity and require a focused attention to ensure that medical providers and social workers within health programs maintain current knowledge of community service providers. Such shifts were experienced throughout the protocol process and having a coordinator that could close loops, share information, and make introductions was widely supported and appreciated.

Buy-in from the top is essential

The development and implementation of a response protocol for victims of human trafficking can only truly succeed in the presence of support from high level hospital executives and management. Dignity Health, which has launched a human trafficking response in 40 hospitals in 3 states under the director of survivor leader Holly Gibbs, provides an example of the success possible when caring for human trafficking survivors is considered part of the hospital system's mission. In this environment, staff are afforded protected time to work on the initiative, and staff are encouraged to attend trainings and meetings. In the H.E.A.T. Institute – HEAL Trafficking pilot project, on the other hand, hospital teams struggled to find time to meet because of all their competing work, which slowed the process considerably. The lack of commitment from the administration at Alta Bates Summit Hospitals resulted in that hospital not developing a protocol, despite the pairing of that hospital with an extremely experienced and dedicated HEAL Trafficking consultant. The hospital champion at Alta Bates, a social worker who was passionate about the project and advanced the work the best she could, eventually left her job. In the absence of support from management or administration, efforts at identifying a new champion failed, and a team did not convene to develop a protocol.

Carla Dartis adds:

- For protocol development and implementation to succeed, it essential for leadership to designate multi-disciplinary teams that have clear roles and boundaries. These teams are charged with specific responsibilities and equipped with the resources and tools needed to implement internal procedures that are designed and integrated from interpersonal violence and other related protocols. It is equally important that these teams are reinforcing training and learning, and serving as an internal resource to fellow staff members and relevant partners with external community based providers.

- Safeguard the time and capacity of the hospital teams to fulfill their roles and responsibilities, or at least develop protocols and policies that call for flexibility to ensure that team mates can provide the resources needed based on best practices within the health care setting or in other health care settings, and as prescribed in the HEAL Trafficking Protocol Toolkit.

- While Alta Bates Sutter Medical staff found that notwithstanding line-staff commitment, transitions in executive leadership and middle management stymied all efforts to go forward in meaningful ways. Having an outside technical assistant provided by HEAL Trafficking, in the form of a physician highly trained and experienced in detecting and working with patients that have been trafficked, working with Alta Bates Sutter Medical Staff created continued pressure for the Alta Bates to continue to identify low-level and even higher level staff to attempt training opportunities and raise awareness. These efforts did result in a few detected cases of labor trafficking (Fall 2017 and Summer 2018).

Resources to Support 24/7 Bedside Advocacy Are Essential

One reason physicians, advanced practice clinicians, and nurses do not inquire about violence with their patients is that they don't know what to do if a patient discloses that they are experiencing violence or abuse, don't understand their mandatory reporting requirements, and fear how long it will take to have a conversation with the patient and figure out how and where to refer them, what needs to be reported, and how to make a mandatory report. Regular training of all medical and nursing professionals on mandatory reporting and the development of easy to follow guidelines and reporting systems can help. The creation of streamlined protocols, built on relationships with community-based agencies to whom providers can make a warm hand-off, also facilitates the process for clinical staff. However, because hospitals operate 24 hours a day, 7 days a week, and most community based organizations do not have the funding to mount a round-the-clock response, many trafficked people present for care during hours of the day when advocates and social service providers are not available. Research studies have demonstrated that emergency departments are a prime location for the identification of human trafficking victims, so the need for 24/7 bedside advocacy response is clear. Without this resource, many trafficking victims miss the opportunity to be connected with resources that can lead to their freedom and recovery from trauma, and health care providers face frustration over failed attempts to improve their patient's health and lives.

Carla Dartis notes:

- Structural concerns as to how to create and know when mandatory reporting and fulfillment of bedside advocacy at medical facility are done correctly must be addressed otherwise protocols will sit on the shelf, evaluations to determine effectiveness will fall short, and possible harm to patients may continue and not abated.

Data, Data, Data

The field of human trafficking has suffered from a lack of solid data and lack of efforts to fund development of scientifically accurate estimates of trafficked people in the US, or in given states, counties, or cities. Numbers pulled from the national human trafficking hotline, which are based on tips called in from the public, and from academic papers that lack appropriate methodology, are often presented as factual prevalence. The data problem is profound at the local level, because governments and agencies can't plan to serve a population if they don't know its size or where the problem is located. In health care, we have not had any mechanism to count how many patients are identified as trafficked in medical settings or with what illnesses and issues they present. The creation of ICD 10 codes for human trafficking, introduced in October 2018, provides a mechanism for the four pilot hospitals to track the recognition of trafficked people in their systems, and

to perform chart reviews to better understand patterns of presentation and medical need. However, the schedule for implementation of ICD 10 trafficking codes in the pilot hospitals is unclear, and implementation of the codes can only succeed with training of billers and coders as well as providers. In addition, ICD 10 codes for trafficking may result in unintended harmful consequences due to stigma and improper disclosure, and therefore must be utilized carefully. Ongoing conversation between three of the four pilot project hospitals about their electronic health records holds great promise for data sharing among the hospitals, which will improve follow up of patients at risk and provide better estimates of the trafficked population seeking health care in Alameda County. (For more reflections, please see the EHR section of this report).

Carla Dartis adds:

- An added hope for the protocol development work in hospitals is to enable another data source to track and compare data to determine a better count regarding prevalence. The Alameda County Department of Children Family Services is still in process in generating accurate reports that reflect the disposition of active cases when CSEC is identified in the child population and information about the kind of cases reported and mandatory reporters that make referrals to the County's Child Abuse Hotline.

The H.E.A.T. Institute requested data from the California Department of Social Services and the Alameda County Department of Child and Family Services, and received two different estimates of the number of CSEC in Alameda County. Medical personnel were not indicated as top reporters to the Alameda County Child Abuse Hotline for CSEC in either report.

Other Reflections and Needs Identified by Hospital Teams, HEAL Trafficking, Levitt Center and H.E.A.T. Institute

1. **Centralized trafficking resources or individualized assistance in managing trafficking resources post discharge:**

   Specifically, there is a need not just for 24/7 bedside assistance or social work available in the hospital, but for someone to help each patient navigate the trafficking resources available once they are discharged. Resources are decentralized and difficult to navigate.

   Because many of the Alameda County human trafficking serving agencies cannot meet all of the needs for survivors, and survivors often have different individual needs that often cannot be met by just one referring agency, the referring health care providers must currently refer patient to several various agencies to attempt to meet each individual's unique circumstances. In addition, it is beyond the scope of health care providers' responsibility to ensure that a patient can access all the

various outside referring agencies that a particular patient may need based on their particular trafficking situation. Many of these needs could be met by having a simplified 24/7 coordinated case management response that is accessible to all hospital systems and that can ideally provide an appropriate and timely response.

2. **Protected time for hospital teams to develop protocols and access training**

   Hospital team members and consultants emphasized the need for protected time to work on trafficking interventions and the need for meetings to be scheduled at a time that is protected and does not interfere with clinic or other mandatory sessions.

3. **Education of other hospital medical and nursing, applied health, administrative and security staff and response protocols including the availability of resources are essential.**

   This is in reference to experiences noted at one of the participating hospitals: "Champions have stopped three unsafe discharges and held patients overnight while awaiting vouchers from A Safe Place Shelter Services." Continued attention and support is needed to ensure health care settings are effective in responding to the needs of trafficked patients and others at risk for harm.

4. **Increased awareness of labor trafficking and development of referral resources for labor trafficking victims/survivors are needed in Alameda and Bay Area. Without this focus, labor trafficking will remain underreported and health care's effectiveness to appropriately respond will be undermined.**

5. **Development of data systems to share information across agencies is a common sense need,** and the absence of agencies working towards that end through ways that do not jeopardize federal HIPAA regulations is essential to effective patient-centered care**.**

6. Mechanism to **keep HT response system coordinated** despite dynamics ofthe process, allowing for ongoing **effective coordination** that minimizes victims/survivors falling through the cracks

7. Expand use of the Alameda County standardized protocol to **mental and behavioral health facilities** including Herrick, Willow Rock, John George Pavilion, etc.

8. When **sharing the standardized protocol** with health systems/facilities throughout Alameda county, **include a copy ofthe HEAL Trafficking Toolkit and a joint letter** from HEAL Trafficking, HEAT Institute and ACDAO. This hopes to be accomplished following the release of this final status report.

9. The hospitals emphasize the need for **funding and capacity building of**

community based providers to serve as bedside advocates who are knowledgeable about trauma-informed care and the array of services available to support human trafficking victims (both domestic and foreign nationals). Ideally, such advocates would be able to respond within 30 to 45 minutes of receiving a call from a health care team. However, based on capacity and funding limitations, this may not be a realistic standard; nonetheless responding in person to an urgent call should occur in less than two hours. Alameda County must find money and a management approach to scale up this capacity.

To access the HEAL Trafficking – Hope for Justice Protocol Toolkit for Developing a Response to Trafficking Victims in Health Care Settings, view a variety of health care protocols, or to request technical assistance with protocol development, please visit

https://healtrafficking.org/protocols-committee/

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