Human Trafficking Response Program

Shared Learnings Manual

Updated – October 2019

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PART I: INTRODUCTION

I. Purpose of Shared Learnings Manual

The Dignity Health Human Trafficking Response (HTR) Program was developed to help ensure that trafficked persons are identified in health care settings and assisted with trauma-informed patient care and services. The purpose of this manual is to share updated HTR Program learnings and materials with Dignity Health associates and others seeking to implement a similar program.

II. Background of Human Trafficking Response Program

The Problem

Human trafficking, or trafficking in persons, is a global issue impacting men, women, and children. Every country is affected, including the United States.[1] In 2018, there were over 10,000 tips of human trafficking reported to the U.S. National Human Trafficking Hotline, nearly 2,500 of which involved children and youth under the age of 18.[2]

Unfortunately, trafficked persons often go unnoticed. A 2014 study published in the *Annals of Health Law* found that nearly 88% of sex trafficking survivors reported some kind of contact with health care *while being exploited*.[3] A 2017 survey report from the Coalition to Abolish Slavery & Trafficking (Cast) found that over half of labor and sex trafficking survivors surveyed had accessed health care at least once while being trafficked. Nearly 97% of that group indicated they had not been provided with information or resources about human trafficking while visiting the health care provider. [4] These and other studies underscore the reality that health care providers are too often unprepared to identify and appropriately assist trafficked persons.

Dignity Health Takes a Stand

In the fall of 2014, Dignity Health, in partnership with Dignity Health Foundation, launched a program to help ensure that trafficked persons are identified in health care settings and assisted with trauma-informed care and services. The program, Dignity Health Human Trafficking Response (HTR) Program, aligns with Dignity Health's core mission and values to

- Deliver compassionate, high-quality, affordable health services
- Serve and advocate for our sisters and brothers who are poor and disenfranchised
- Partner with others in the community to improve the quality of life

The launch began with a milestone conference in San Francisco that included nationally known subject matter experts Carissa Phelps, author of *Runaway Girl: Escaping Life on the Streets*,[5] and David Batstone, Founder and President of the anti-trafficking organization, Not For Sale.[6]

To learn more about the HTR Program, a program that is both survivor-led and survivor-informed, please visit https://www.dignityhealth.org/hello-humankindness/human-trafficking.

PART II: ESTABLISHING A HUMAN TRAFFICKING RESPONSE PROGRAM

I. Program Goals

The goals for the Dignity Health Human Trafficking Response (HTR) Program are to help ensure that trafficked persons are identified in health care settings and appropriately assisted with trauma-informed patient care and services. This program, which includes education and victim response policies and procedures, was implemented first in Dignity Health emergency departments, followed by labor & delivery and postpartum departments. Education and victim response procedures are now being implemented house-wide in each acute care facility, and also in ambulatory care settings, including clinics, community centers, and outreach sites.

Education and Support for Staff

In order to ensure health care professionals are truly equipped to identify trafficked persons, Dignity Health recognized that education must go further than simply giving staff a list of signs and symptoms. Trafficking in persons is a complex issue with many misconceptions often perpetuated in the media. For many Americans, the term *human trafficking* is associated strictly with images of exploitation overseas. Even among those who do recognize that this crime occurs domestically, the term often conjures up an image of people being smuggled into the country or girls being chained to beds. If this is a health care professional's understanding of what human trafficking looks like in the United States, then that professional has likely missed, and will continue to miss, opportunities to intervene in human trafficking cases.[7]

In partnership with subject matter experts in various fields, including survivor leaders, Dignity Health's HTR Program Leadership developed three courses to educate employees and associates about human trafficking and how to provide trauma-informed care and services to patients, including those who may be experiencing abuse, neglect, or violence:

- *Human Trafficking 101: Dispelling the Myths*[8]
- *Trauma-Informed Approach to Patient Care and Services*[9]
- *PEARR Tool: Trauma-informed Victim Assistance in Health Care Settings* [10]

Dignity Health's *Human Trafficking 101: Dispelling the Myths* is designed to provide basic education about trafficking in persons for all staff, physicians, volunteers, and contract employees. It is critical to educate all staff on the realities of labor and sex trafficking; this includes security officers, patient registration personnel, and other support staff who may observe red flags in the facility's hallways, waiting areas, or parking lots. See Part III of this manual for a two-page summary of the module, *Human Trafficking 101: Dispelling the Myths.*

Dignity Health's *Trauma Informed Approach to Patient Care and Services* introduces the topic of trauma-informed care. A trauma-informed approach should be practiced with all patients as trauma is pervasive and can include life events such as witnessing a major car accident, losing a family member, or experiencing a natural disaster. The guiding principles of a trauma-informed

approach include safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender considerations.

Dignity Health's *PEARR Tool: Trauma-Informed Victim Assistance in Health Care Settings* offers an in-depth overview of the "PEARR Tool", a tool developed by Dignity Health in partnership with HEAL Trafficking and Pacific Survivor Center. This tool describes how to offer victim assistance to patients in a trauma-informed manner. This assistance is meant for patients experiencing any type of abuse, neglect, or violence, including labor or sex trafficking. To access these modules, please visit https://www.dignityhealth.org/hello-humankindness/human-trafficking. For information about training and technical assistance, please contact Dignity Health HTR Program Leadership at StopHumanTrafficking@DignityHealth.org.

NOTE: When presenting these topics, keep in mind that audience members can become traumatized by the material and audience members can themselves be victims/survivors of human trafficking or other traumatic experiences. Consider ways to prepare your audiences for the subject matter and provide them with options for self-care, especially if the content becomes overwhelming (e.g., encourage audience members to step out of the room if/as needed).

Education and Support for the Community

In order to ensure health care professionals are truly equipped to assist trafficked persons, Dignity Health recognized that our efforts must reach beyond our facilities' walls. The communities served by Dignity Health must also be educated and equipped to support trafficked persons with victim services and opportunities for survivor empowerment. Therefore, the HTR Program also assesses communities for gaps and needs and, whenever possible, seeks ways to bolster local efforts to prevent victimization, protect victims, and empower survivors.

This includes efforts to ensure that law enforcement and other first responders are educated on human trafficking and a trauma-informed approach to victim assistance. It also includes efforts to ensure emergency victim services are available 24/7. Ideally, victim services will include options for residential care as well as outreach support. Dignity Health seeks ways to ensure that services and empowerment opportunities are available for a victim/survivor of any type of trafficking (i.e., labor or sex); any age (i.e., children, youth, and adults of all ages); any gender identity or sexual orientation; and any race, ethnicity, or religion. We also seek ways to support services for trafficked persons with children and other family members, as well as pets.

As you establish goals for your own program, Dignity Health encourages you to consider ways to impact your facility (or facilities) *and* your community (or communities).

II. Program Structure and Leadership

Dignity Health is one of the largest health care systems in the nation and the largest hospital provider in California. As such, implementing the HTR Program across such a large system required a strategic and well-informed approach (described below). As you implement your own program, you may want to consider a similar strategy according to the size of your system and scope of your goals. Dignity Health's program was initially launched and championed by two Executive Leaders: the Senior Vice President (VP) of Patient Care Services and System Chief Nurse Executive and the Executive VP for Sponsorship, Mission Integration & Philanthropy.

NOTE: Seeking executive sponsors to champion your program is essential. Also, establishing a multidisciplinary steering committee is recommended. Committee members can represent a cross section of key stakeholder groups and disciplines and can provide vision, insight, and guidance to Program Leadership on all aspects of the HTR Program. See Figure 1 for an example organizational chart based on the Dignity Health HTR Program structure and leadership in 2017.

NOTE: Dignity Health and Catholic Health Initiatives (CHI) recently aligned to form CommonSpirit Health. As such, the HTR Program is transitioning to the "Violence and Human Trafficking Prevention and Response Program" and will include efforts to prevent and respond to various types of violence, including human trafficking. The current Executive Sponsors for this program are Colleen Scanlon, Chief Advocacy Officer, and Kathleen Sanford, Chief Nursing Officer. CommonSpirit's community-based violence prevention efforts will be designed according to CHI's United Against Violence model. To learn more about this model, please visit https://www.catholichealthinitiatives.org/en/our-mission/advocacy/violence-prevention.html.

Service Area/Regional/Facility Task Force

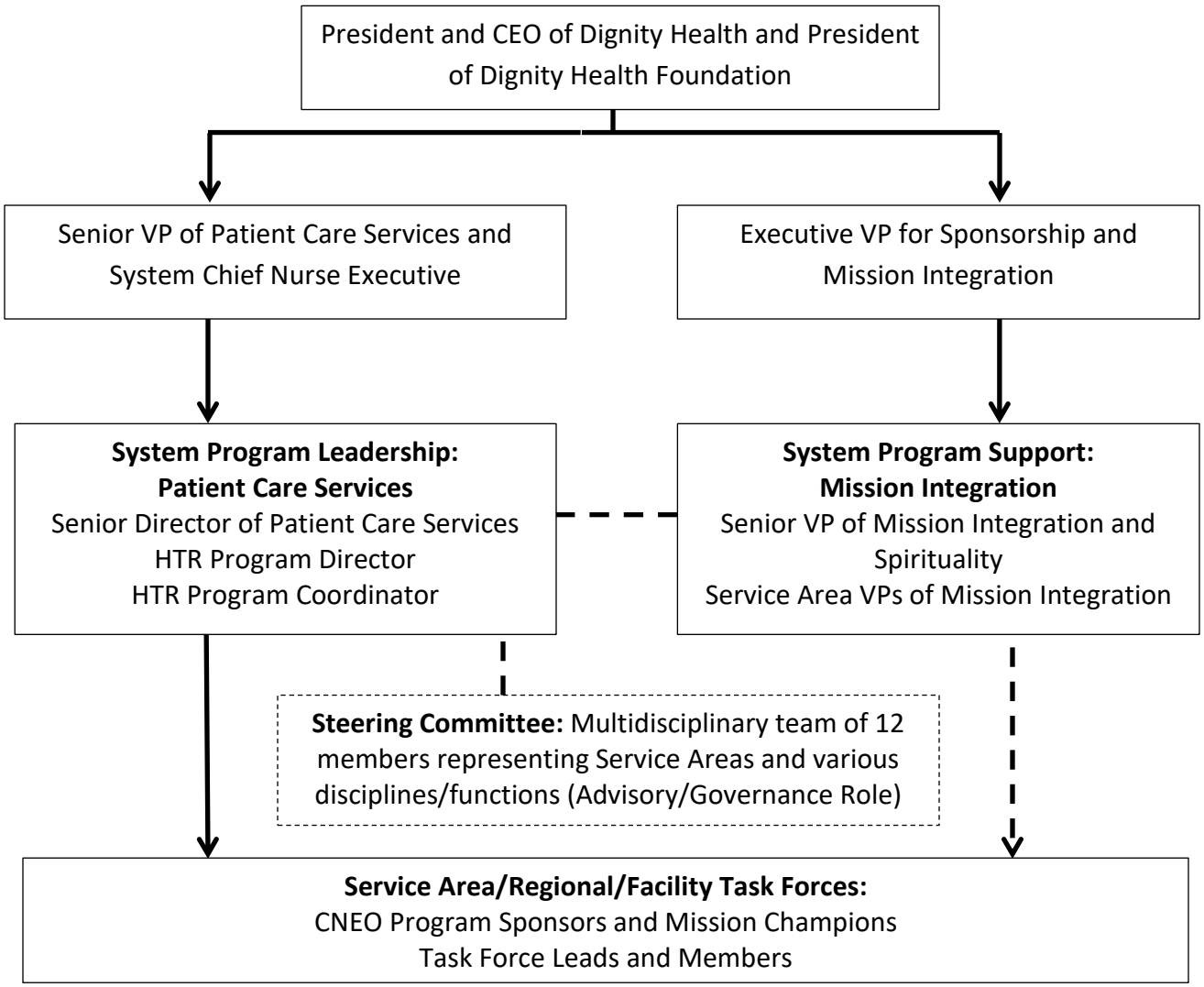
With input from the Steering Committee, HTR Program Leadership chose to implement the HTR Program first in Dignity Health emergency departments, followed by labor & delivery and postpartum departments. As such, the HTR Program was rolled out first to acute care facilities. Each facility's Chief Nursing Executive Officer (CNEO) serves as the facility-based Program Sponsor with support from a "Mission Champion" (often the Mission Integration Director).

At each facility, the CNEO and Mission Champion established an internal multidisciplinary HTR Task Force. Each HTR Task Force has members representing disciplines similar to those represented on the Steering Committee. For each discipline represented, at least one representative is expected to have capacity to attend and authority to make decisions on behalf of that department. The purpose of the Task Force is to ensure that HTR Program goals are met in the facility and local community, with support from HTR Program Leadership.

Each CNEO and Mission Champion has the option to choose a Task Force Lead (or Leads) to champion on their behalf. When assigning Task Force Leads, CNEOs and Mission Champions are encouraged to consider individuals with personal passion and commitment to the cause, as well as ability and capacity to serve. Expected duties include, but are not limited to the following: 1) assigning and replacing Task Force members as needed, 2) prioritizing and assigning action items and keeping track of progress, 3) scheduling Task Force meetings, and 4) communicating obstacles and ideas to HTR Program Leadership. See Part III of this manual for an example HTR Task Force Checklist, which lists action items for each Task Force.

NOTE: With approval from each facility's CNEO and Mission Champion, each HTR Task Force can include more than one acute care facility in each region and be regionally or Service Area-based. As the program extends to include other Dignity Health facilities (e.g., clinics, physicians' offices, etc.), additional members may be added or Task Forces created.

Figure 1. Example organizational chart based on Dignity Health's HTR Program in 2017.



III. Policies and Procedures

Before implementing education on human trafficking or other types of abuse, neglect, or violence, it is imperative to first establish victim response policies/procedures. These procedures should include information on community agencies (e.g., law enforcement, child welfare, adult protective services, *and* community-based organizations that provide support and services to victims/survivors). While policies/procedures may change over time, it's important to have clear baseline instructions for staff to follow if and when a patient is identified as a potential victim.

The following policies and procedures are implemented at Dignity Health.

NOTE: Dignity Health continually refines HTR Program goals, strategies, and policies/ procedures. For the most up-to-date information, please visit https://www.dignityhealth.org/hello-

humankindness/human-trafficking. Dignity Health staff, physicians, volunteers, and contract employees are advised to contact HTR Program Leadership for up-to-date and complete HTR Program information, including educational modules and policies/procedures.

Abuse, Neglect, and Violence Policy

Dignity Health's Abuse, Neglect, and Violence Policy was designed based on years of case debriefings with frontline staff, as well as collaborations with subject matter experts in various fields and best practices gleaned from agencies in other fields addressing violence, e.g., the "CUES Model" from Futures Without Violence. When the HTR Program first launched, Program Leadership and the Steering Committee designed a "Case Record" to collect information from frontline staff about what went well or any issues that arose with procedures.

NOTE: The Case Record was not meant to be part of the patient's record; it was meant to be used as a tool to vet the effectiveness of the victim response procedures.

Frontline staff were asked to complete the Case Record anytime they encountered a patient they thought to be a potential victim of human trafficking. Then, HTR Program Leadership debriefed the case with Task Force Leads and staff and refined the procedures accordingly. After numerous refinements, Dignity Health implemented its Abuse, Neglect, and Violence Policy.

This policy is based on a wealth of information and learnings gathered over the years such as:

- A victim response procedure should not be designed in a way that assumes that red flags (i.e., risk factors or indicators) will be observed in triage. Red flags may be missed in triage and may be observed by staff at any time throughout the patient process.
- A victim response procedure should not be designed for one type of abuse, neglect, or violence. A patient may be a victim of multiple types of violence (e.g., a person may be experiencing labor trafficking, domestic violence, and sexual violence). Also, red flags for one type of violence are often similar to other types. As such, victim response procedures should be inclusive of any type of abuse, neglect, or violence.
- It's nearly impossible to write a victim response procedure that captures any and all variables that might occur when caring for a patient who is experiencing abuse, neglect, or violence. For this reason, education on a trauma-informed approach to patient care and services is essential. If a health care professional provides patient care that reflects the guiding principles of a trauma-informed approach, then that professional is more likely to create a patient-centered experience and less likely to re-traumatize a patient.

See Part III of this manual for an example template of a clinical policy and procedure that is applicable to acute care facilities and is based on Dignity Health's Abuse, Neglect, and Violence policy. Also provided is an example Case Record.

PEARR Tool

The PEARR Tool is a key component of Dignity Health's Abuse, Neglect, and Violence policy. Dignity Health developed the PEARR Tool, in partnership with HEAL Trafficking and Pacific Survivor Center, to help guide social workers, nurses, chaplains, and other health professionals

on how to provide victim assistance to patients in a trauma-informed manner. When caring for a patient, a health care provider is advised to:

- **P**rovide privacy
- **E**ducate
- **A**sk
- **R**espect & **R**espond

The PEARR Tool is based on a universal education approach, which focuses on educating patients about abuse, neglect, or violence prior to, or in lieu of, screening patients with questions. The goal is to have an informative, normalizing, and developmentally- and culturally-appropriate conversation with patients in order to create a context for affected patients to share their own experiences naturally. See Part III of this manual or download the PEARR Tool online at https://www.dignityhealth.org/hello-humankindness/human-trafficking.

Community Resource List

An important part of victim response is maintaining a list of community agencies in order to assist with patient referrals. This includes law enforcement, child welfare, adult protective services, and organizations that provide support/services to victims/survivors of abuse, neglect, or violence. As required by Joint Commission, each Dignity Health acute care facility maintains a list of public and private community agencies and makes this list available to frontline staff. As you establish similar lists, please note that many organizations limit services to specific populations based on funding sources. They may only be able to serve specific age groups or genders, and may need to limit services based on type of victimization, presence of children, and ages of children. Therefore, in addition to contact information, Dignity Health recommends including descriptions of services provided by the agencies, as well as populations served.

IV. Program Implementation

Due to the size of the Dignity Health enterprise, responsibility of HTR Program implementation was delegated to the Task Force at each hospital with support and guidance from HTR Program Leadership. A kick-off meeting with each Task Force helped to launch the program at each site; and, whenever possible, the meeting included a survivor speaker. HTR Program Leadership provided a checklist to HTR Task Forces to help with step-by-step action items for program implementation. See Part III of this manual for an example template of this checklist.

PART III: DIGNITY HEALTH HUMAN TRAFFICKING RESPONSE PROGRAM MATERIALS

NOTE: Dignity Health continually refines HTR Program goals, strategies, and policies/ procedures. For the most up-to-date information, please visit https://www.dignityhealth.org/hello-humankindness/human-trafficking. Dignity Health staff, physicians, volunteers, and contract employees are advised to contact HTR Program Leadership for up-to-date and complete HTR Program information, including educational modules, policies, and procedures.

Summary of *Human Trafficking 101: Dispelling the Myths*[11]

Human trafficking is a global issue. Although this crime crosses all age, economic, cultural, gender, sexual orientation, racial, and social lines, traffickers often target persons in situations of **vulnerability** Worldwide forms of human trafficking include child soldiers, child brides, and organ trafficking. Following are **10 myths/misconceptions** associated with human trafficking.

Myth #1: Human trafficking only happens overseas.
Truth: Every country is affected by human trafficking, including the United States. The USA passed federal legislation **to outlaw two common forms of human trafficking:** sex trafficking and labor trafficking. According to federal law, human trafficking means **forcing or coercing a person to perform commercial sex or labor/services**. Commercial sex is any sex act in which money or something of value is exchanged. Under federal law, anyone under age 18 involved in commercial sex is automatically a victim of human trafficking – no force or coercion is required.

Myth #2: Only foreign nationals/immigrants are trafficked in the United States.
Truth: In 2018, nearly 11,000 tips of human trafficking were reported **and at least 1,237 of these tips involved U.S. citizens or lawful permanent residents.**

Myth #3: Human trafficking and human smuggling are the same crime.
Truth: Human trafficking is **NOT** the same crime as human smuggling. Human trafficking is a violation of someone's human rights. Human smuggling is a violation of a country's immigration laws. A person can consent to being smuggled into the country; however, if that person is forced or coerced into commercial sex or labor/services, then they are a victim of human trafficking.

Myth #4: Sex trafficking could never occur in a legal setting like a strip club.
Truth: Sex trafficking has been discovered in legal business settings (e.g., strip clubs, escort services, and pornography). **Regardless of the location or legality**, any person induced to perform commercial sex or labor through force or coercion is a victim of human trafficking.

Myth #5: Everyone engaging in prostitution is doing so by choice.
Truth: Oftentimes adults are "choosing" to perform commercial sex work due to **a lack of options** as opposed to a free choice. We must refrain from passing judgment and we must offer compassion and resources to persons in need of assistance.

Myth #6: Victims of human trafficking will reach out for help.
Truth: Oftentimes victims of sex trafficking, especially youth, do not self-identify as victims. Due to prior abuse, victims may not realize they are being manipulated or exploited. Sex traffickers often target vulnerable and abused youth. Victims of sex or labor trafficking may blame themselves, may fear authorities, or may fear retaliation by traffickers. Foreign national victims may not speak English and may not know their rights in America.

Myth #7: Only women and girls are victims of sex trafficking.
Truth: Men and boys are also victims of sex trafficking. Traffickers often target young men and boys living on the streets, many of whom identify as LGBTQ.

Myth #8: Child sex trafficking could never occur in my community.
Truth: Child sex trafficking has been reported **in every region served by Dignity Health**.

Myth #9: All sex traffickers are stereotypical pimps.
Truth: The term *pimp* is often associated with a stereotypical pimp (e.g., flashy hat and clothes). These pimps are no longer the norm. "Pimping" has become so normalized and even glamorized in the media that many young men and boys, especially gang members, *want* to become pimps. Gangs consider it easier to sell a person for sex than to sell drugs or guns. **Drugs and guns can be sold only once. A person, however, can be sold for sex over and over.** Anyone can be a trafficker, including family members, friends, and neighbors. This crime is not exclusive to known pimps or gang members. One mother sold her 7- and 14-year-old daughters for sex.

Myth #10: Human trafficking refers only to sex trafficking.
Truth: Human trafficking is an umbrella term that includes both sex and **labor trafficking**. Unfortunately, labor trafficking often does not get as much exposure in the media as does sex trafficking. Labor trafficking has been identified in industries like agriculture, hospitality, domestic work (e.g., live-in maid), and traveling sales crews. Red flags include the following:

- Victims may be charged a fee that is impossible to pay off (i.e., debt bondage).
- Victims may be forced to work 12+ hours per day, 7 days per week.
- Victims may not be allowed to leave the work premises and may be forced to sleep on the floor or on a cot in the back of the business.
- Victims of domestic servitude may be forced to sleep in the home. Victims working in traveling sales crews may be forced to sleep in a van or other vehicle.

As defined by the Trafficking Victims Protection Act (TVPA), **there are three victim populations** of criminal human trafficking:

1. Anyone under age 18 induced to perform commercial sex **under any circumstance**
2. Any adult induced to perform commercial sex through **force, fraud, or coercion**
3. Anyone, **of any age**, induced to perform labor/services through force, fraud, or coercion.

Red Flags in the health care setting include (but are not limited to) patients with controlling companions (e.g., a companion who insists on holding a patient's passport or work visa, a companion who insists on interpreting for a patient, a companion who refuses to leave the patient's side); patients not speaking for themselves; patients with signs of medical/physical neglect; and patients who are submissive, fearful, hypervigilant, and/or uncooperative.

What to do if you see red flags: Refer to the Abuse, Neglect, and Violence Policy, which includes the **PEARR Tool: P**rovide privacy, **E**ducate, **A**sk, **R**espect and **R**espond.

The **National Human Trafficking Hotline** is available 24/7 to report suspicious activity, to inquire about local resources, and to seek support if you or someone you know may be a victim of human trafficking: **1-888-373-7888**. Access Dignity Health's module, *Human Trafficking 101: Dispelling the Myths:* dignityhealth.org/hello-humankindness/human-trafficking.

Example Clinical Policy and Procedure

CLINICAL POLICY AND PROCEDURE – EXAMPLE

SUBJECT:	Abuse, Neglect, and Violence – Identification and Intervention For Care and Treatment of Patients Who May be Victims/Survivors		
POLICY NUMBER:	[Policy Number]	**DATE APPROVED:**	[Date Policy Approved]
APPLIES TO:	Acute Care Entities Only		

POLICY:

A. [Insert Name] is committed to assisting in the identification of patients who may be victims of abuse, neglect, and/or violence, delivering high-quality care and services that reflect principles of a trauma-informed approach, and assisting with referrals or access to public and private community agencies that can provide or arrange for additional assessment or care. Each facility will maintain a list of community agencies.
B. [Insert Name] is committed to protecting patients while under its care and service.
    1. [Insert Name] strictly prohibits any form of mistreatment against a patient by staff, physicians, volunteers, contract employees, visitors, and other patients.
    2. Any allegations, observations, or suspicions of abuse, neglect, or violence, including misappropriation of property, against a patient who is under [Insert Name's] care and service will be investigated.

AFFECTED DEPARTMENTS: All Clinical Departments

PROCEDURE:

A. Assess or reassess the patient for risk factors and observable signs or symptoms (verbal/ nonverbal indicators) of abuse, neglect, or violence upon admission or entry into the facility and with change in condition. The medical well-being of the patient always comes first. (See ATTACHMENT A: PEARR Tool: Trauma-Informed Approach to Victim Assistance in Health Care Settings).

B. Document risk factors and observable signs/symptoms in the electronic health record. Document additional information, including wounds, injuries, and patient statements.

C. For patient exhibiting risk factors or signs/symptoms of abuse, neglect, or violence, make a referral to Social Work. Evaluate the need to make a referral to a Chaplain or other support personnel to provide professional emotional or spiritual support.

CLINICAL POLICY AND PROCEDURE – EXAMPLE

D. Provide the patient with abuse, neglect, or violence education, including contact information for hotlines or community agencies, and ask if the patient requires assistance. (See ATTACHMENT A: PEARR Tool: Trauma-Informed Approach to Victim Assistance in Health Care Settings).

E. If the patient accepts/requests assistance with accessing public or private community agencies, then document the patient's consent and which agencies were contacted.

F. If the patient accepts/requests a sexual assault forensic exam (SAFE), then the patient must be medically cleared before transport to the Sexual Assault Response Team (SART) Center or equivalent setting.

   1. Notify law enforcement in the jurisdiction where the crime occurred. The responding law enforcement agency will take the patient's statements and determine whether or not to order a sexual assault forensic exam. If law enforcement orders the exam, then the law enforcement agency will arrange for transport of the patient, per the patient's consent, to the appropriate SART Center or equivalent setting.
      a. If the patient accepts/requests a sexual assault forensic exam, then law enforcement must be notified regardless of reporting requirements. However, the Violence Against Women Act (VAWA) allows for a sexual assault forensic exam to be completed even if a victim declines to provide statements or to make a report with law enforcement. In such cases, provide the patient with contact information for the SART Center or equivalent contact.
   2. Preserve evidence as much as possible; for example
      a. Discourage the patient from washing, eating, or drinking.
      b. Do not clean the victim's genitalia or perform a catheterization or speculum examination (unless there is heavy vaginal bleeding).
   3. Medication for pregnancy prevention and sexually transmitted infection (STI) prophylaxis, as well as a referral for HIV post-exposure prophylaxis (PEP), will be provided at the SART Center or equivalent setting as applicable.
   4. For questions or concerns, call the appropriate SART Center, or equivalent contact, and refer to your facility's procedures.

G. Report safety concerns (e.g., potential abuser is on-site or may arrive on-site) to Security and Nurse Shift Manager/Shift Administrator/Supervisor.

H. Report allegations, observations, and suspicions of abuse, neglect, or violence to Nurse Shift Manager/Shift Administrator/Supervisor, Social Work, and/or Patient Safety Officer.

I. Report allegations, observations, and suspicions of abuse, neglect, or violence to authorities/ agencies as required or permitted by law or regulation.

J. If there are concerns regarding procedural steps, particularly a variance or breakdown in policies or procedures, notify the Nurse Shift Manager/Shift Administrator/ Supervisor, or notify someone in a higher chain of command, and complete an event report. This includes a lack of response or negative response toward patients from private or public community agencies.

K. Contact Nurse Shift Manager/Shift Administrator/Supervisor or Employee Assistance Program (EAP) for concerns regarding secondary trauma, as needed.

CLINICAL POLICY AND PROCEDURE – EXAMPLE

TRAINING AND EDUCATION

A. During Orientation and Re-Orientation, educate staff, physicians, volunteers, and contract employees; this includes but is not limited to:
   1. Risk factors for and signs/symptoms (verbal/nonverbal indicators) of abuse, neglect, or violence and follow-up procedures for patients who may be victims/survivors, e.g., trauma-informed approach to patient care, PEARR Tool.
   2. Best practice guidelines regarding documentation of wounds, injuries, and patient statements.
   3. Process for patients requesting sexual assault forensic exam.

DEFINITIONS:

Abuse: The Centers for Medicare and Medicaid Services (CMS) defines abuse as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish." Per CMS, this includes "staff neglect or indifference to infliction of injury or intimidation of one patient by another."

Community agencies: Private and public community agencies refers to any agency that can provide continued assessment and care to patients who may be victims of abuse, neglect, or violence. This includes county welfare agencies, law enforcement agencies, victim advocacy agencies, and agencies that provide direct services to victims/survivors of abuse, neglect, and violence.

Neglect: CMS defines neglect as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

PEARR Tool: The "PEARR Tool" offers guidance to social workers, nurses, and other health care professionals on how to provide trauma-informed assistance to patients who are at high-risk of, or who are exhibiting signs or symptoms of, abuse, neglect, or violence. The PEARR Tool is based on a universal education approach, which focuses on educating patients about abuse, neglect, or violence prior to, or in lieu of, screening patients with questions. The goal is to have an informative and normalizing, yet developmentally- and culturally-appropriate, conversation with patients in order to create a context for them to share their own experiences. The full version of the PEARR Tool is available to download online: https://www.dignityhealth.org/hello-humankindness/human-trafficking.

Secondary trauma: Secondary traumatic stress disorder, or compassion fatigue, is a natural but disruptive by-product of working with traumatized clients. Many types of professionals, such as physicians, psychotherapists, human service workers, and emergency workers, are vulnerable to developing this type of stress, though only a subset of such workers experience it.

Sexual Assault Forensic Exam (SAFE): A sexual assault forensic exam (SAFE) may also be referred to as a "rape kit", sexual assault evidence kit (SAEK), or other name. Sexual Assault Forensic Examiners (SAFEs) and Sexual Assault Examiners (SAEs) are health care professionals who have been instructed and trained to complete a sexual assault forensic exam. They also provide support and referrals as needed. They can be nurses, nurse practitioners, physicians, and physician assistants. They perform the exam and testify as expert witnesses when needed.

CLINICAL POLICY AND PROCEDURE – EXAMPLE

Sexual Assault Nurse Examiner (SANE): A Sexual Assault Nurse Examiners (SANE) is a Registered Nurse who has received special training to provide comprehensive care to sexual assault victims, including a sexual assault forensic exam (SAFE). In addition, SANEs may provide expert testimony if a case goes to trial.

Sexual Assault Response Team (SART): A sexual assault response team (SART) is a community-based team that coordinates the response to victims of sexual assault. The team may be comprised of sexual assault nurse examiners (SANEs), hospital personnel, victim advocates, law enforcement, prosecutors, judges, and any other professionals with a specific interest in assisting victims of sexual assault.

Trauma-Informed Approach: A trauma-informed approach includes an "understanding of trauma and an awareness of the impact it can have across settings, services, and populations." This includes understanding how trauma can impact patients and the professionals attempting to assist them. As described by the Substance Abuse and Mental Health Services Administration (SAMHSA), the guiding principles of a trauma-informed approach are safety; trustworthiness and transparency; peer support and mutual self-help; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.

Violence: The World Health Organization (WHO) defines violence to include "neglect and all types of physical, sexual, and psychological abuse". Violent acts include, but are not limited to, physical or sexual assault, sexual molestation, rape, human trafficking (e.g., sex and labor trafficking), harassment, stalking, kidnapping/ abduction, shootings, corporal punishment, and involuntary seclusion.

Violent acts can be committed against a patient before, during, or after the person's visit to a Dignity Health facility. Also, any person can be a perpetrator, including staff, physicians, volunteers, contract employees, family members/ visitors, and/or other patients.

REFERENCES:

A-0145 (Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08) §482.13(c)(3) - The patient has the right to be free from all forms of abuse or harassment. Interpretive Guidelines §482.13(c)(3)

Rape Abuse Neglect Incest National Network (RAINN). *What is a Rape Kit*, https://www.rainn.org/articles/what-sanesart

Rape Abuse Neglect Incest National Network (RAINN). *What is a SANE/SART*, https://www.rainn.org/articles/what-sanesart

Substance Abuse and Mental Health Services Administration, *Key Terms: Definitions,* SAMHSA News, Spring 2014, Volume 22, Number 2, https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/key_terms.html

Substance Abuse and Mental Health Services Administration, SAMHSA News, "Guiding Principles of Trauma-Informed Care", Spring 2014, Volume 22, Number 2, https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/guiding_principles.html

CLINICAL POLICY AND PROCEDURE – EXAMPLE

The Joint Commission.
https://www.jointcommission.org/dateline_tjc/identifying_human_trafficking_victims_among_your_patients/

World Health Organization, *World report on violence and health,*
http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf
(accessed March 10, 2018)

U.S. Department of Health and Human Services, Administration for Children and Families, Secondary Traumatic Stress, https://www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress

Violence against Women Act of 1994. Washington, D.C.: U.S. Dept. of Justice, Violence Against Women Office, 1996.

STATUTORY/REGULATORY AUTHORITIES: *(if applicable)*

Centers for Medicare and Medicaid Services (CMS). State Operations Manual §483.13

The Joint Commission

CLINICAL POLICY AND PROCEDURE – EXAMPLE

Summary of Key Procedural Steps

Assess or reassess patient for risk factors and observable signs/symptoms of abuse, neglect, or violence upon admission or entry into facility and with change in condition. (See Page 2 of PEARR Tool for examples of risk factors and indicators).

Document risk factors and observable signs/symptoms in electronic health record. Document additional information, including wounds, injuries, and patient statements.

For patient exhibiting risk factors or signs/symptoms of abuse, neglect, or violence, **make referral to Social Work**. Evaluate need to make referral to Chaplain or other support personnel for professional emotional or spiritual support.

Provide patient with abuse, neglect, or violence education, including contact information for hotlines or public/private community agencies, and ask if patient requires assistance. (**See PEARR Tool: Provide privacy, Educate, Ask, Respect and Respond**).

If patient accepts/requests assistance with accessing community agencies, then document patient's consent and which agencies were contacted. If patient accepts/requests sexual assault forensic exam, then patient must be medically cleared before transport to Sexual Assault Response Team (SART) Center or equivalent setting.

Report safety concerns (e.g., potential abuser is on-site or may arrive on-site) to Security and Shift Administrator/Supervisor.

Report allegations, observations, and suspicions of abuse, neglect, or violence to:
- Shift Administrator/Supervisor, Social Work, and/or Patient Safety
- External authorities/agencies as mandated or permitted by law or regulation.

If there are concerns regarding procedural steps, particularly a variance or breakdown in policies/procedures, notify NSM/Shift Administrator/Supervisor, or notify someone in a higher chain of command, and **complete an event report**. This includes a lack of response or negative response from private or public community agencies.

Contact Shift Administrator/Supervisor or Employee Assistance Program (EAP) for concerns regarding **secondary trauma**, as needed.

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CLINICAL POLICY AND PROCEDURE – EXAMPLE

ATTACHMENT A: PEARR TOOL

PEARR Tool

Trauma-Informed Approach to Victim Assistance in Health Care Settings

In partnership with HEAL Trafficking and Pacific Survivor Center, Dignity Health developed this tool, the "PEARR Tool", to guide physicians, social workers, nurses, and other health care professionals on how to provide **trauma-informed assistance** to patients who are at high risk of abuse, neglect, or violence. The PEARR Tool is based on a **universal education approach**, which focuses on educating patients about abuse, neglect, or violence prior to, or in lieu of, screening patients with questions.

The goal is to have an informative and normalizing, yet developmentally- and culturally-appropriate, conversation with patients in order to create a context for them to share their own experiences.

A double asterisk ** indicates points at which this conversation may end. Refer to the double asterisk ** at the bottom of this page for additional steps. The patient's immediate needs (e.g., emergency medical care) should be addressed before use of this tool.

P – Provide Privacy

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

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

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

E – Educate

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

A – Ask

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

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

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

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

   USPSTF = US Preventive Services Task Force

RR – Respect and Respond

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

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

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

CLINICAL POLICY AND PROCEDURE – EXAMPLE

PEARR Tool – Risk Factors, Indicators, and Resources

Child Abuse and Neglect

Risk factors include (not limited to): Concerns of domestic violence (DV) in home; parents/guardians exhibiting mental health or substance use disorders; parents/guardians who are overly stressed; parents/guardians involved in criminal activity; presence of non-biological, transient caregivers in home.

Potential indicators of victimization include (not limited to): Slower-than-normal development, failure to thrive, unusual interaction with parent, signs of mental health disorders [e.g., depression, post-traumatic stress disorder (PTSD), self-harm], sudden difficulty in school, medical or physical neglect, sudden changes in behavior, new or unusual fears/anxiety, unexplained injuries (e.g., bruises, fractures, burns – especially in protected areas of child's body), injuries in pre-mobile infants, sexually transmitted infections (STIs).

For additional information, *see Child Welfare Information Gateway: www.childwelfare.gov*

Abuse/Neglect of Vulnerable Adults (e.g., elder and dependent adults)

Risk factors include (not limited to): Concerns of mental health or substance use disorder with caregiver, caregiver exhibits hostile behavior, lack of preparation/training for caregiver, caregiver assumed responsibilities at early age, caregiver exposed to abuse as child.

Potential indicators of victimization include (not limited to): Disappearing from contact; signs of bruising or welts on the skin; burns, cuts, lacerations, puncture wounds, sprains, fractures, dislocations, internal injuries or vomiting; wearing torn, stained, bloody clothing; appearing disheveled, in soiled clothing; appearing hungry, malnourished.

For additional information, *see National Association of Adult Protective Services (NAPSA): napsa-now.org; Centers for Disease Control and Prevention (CDC): cdc.gov/violenceprevention/elderabuse/index.html*

Domestic Violence/Intimate Partner Violence (IPV)

DV/IPV can affect anyone of any age, gender, race, or sexual orientation. **Risk factors** include (not limited to): Low self-esteem, low income, low academic achievement, young age, aggressive/delinquent behavior as youth, heavy alcohol/drug use, depression, suicide attempts, isolation, anger, and hostility.

Potential indicators of victimization include (not limited to): Injuries that result from abuse or assault, e.g., signs of strangulation, bruises, burns, broken bones; psychological conditions such as anxiety, depression, sleep disturbances; sexual and reproductive health issues, e.g., STIs, unintended pregnancy.

For additional information, *see National DV Hotline: thehotline.org; CDC: cdc.gov/violenceprevention/intimatepartnerviolence/index.html*

Sexual Violence

Sexual violence crosses all age, economic, cultural, gender, sexual, racial, and social lines. Some statistics from Rape Abuse & Incest National Network (RAINN): More than 300,000 persons are victimized annually; ages 12-34 are the highest risk years. Female college students (ages 18-24) are three times more likely than women in general to experience sexual violence. One in 33 American men have experienced an attempted or completed rape. And, 21% of transgender, gender-queer, noncomforming (TGQN) college students have been sexually assaulted.

Potential indicators of victimization include (not limited to): STIs, pregnancy, depression, PTSD.

For additional information, *see RAINN: rainn.org; CDC: cdc.gov/violenceprevention/sexualviolence/index.html*

Human Trafficking (e.g., labor and sex trafficking)

Although human trafficking crosses all age, economic, cultural, gender, sexual orientation, racial, and social lines, traffickers often target persons in situations of vulnerability. **Risk factors** include (not limited to): Running away or homelessness (particularly for youth), history of interpersonal abuse or violence, involvement in commercial sex industry, minority/immigrant status.

Potential indicators of victimization include (not limited to): Accompanied by controlling companion; inconsistent history; medical or physical neglect; and submissive, fearful, hypervigilant, or uncooperative behavior.

For additional information, *see National HT Hotline: humantraffickinghotline.org*

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), **a trauma-informed approach** includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. This includes understanding how trauma can impact patients, families, communities, and the professionals attempting to assist them.

SAMHSA describes the guiding principles of a trauma-informed approach as follows: safety; trustworthiness and transparency; peer support and mutual self-help; collaboration and mutuality; empowerment, voice, and choice; and consideration of cultural, historical, and gender issues.

To learn more, *please see SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach: https://store.samhsa.gov/system/files/sma14-4884.pdf*

For more information, visit dignityhealth.org/human-trafficking-response

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Example Case Record

Case Record – Abuse, Neglect, and Violence

PATIENT LABEL HERE - INTERNAL USE ONLY

Use PEARR Tool to provide trauma-informed victim assistance

Describe patient's age range, gender identity, and other demographics.

Describe what indicated patient may be at risk of abuse, neglect, or violence.

Did you arrange for Private setting to speak with patient alone? ☐ Yes ☐ No ☐ N/A

Did you Educate patient about abuse, neglect, or violence? ☐ Yes ☐ No ☐ N/A

Did you Ask patient about concerns of abuse, neglect, or violence? ☐ Yes ☐ No ☐ N/A

Did you Respect patient's wishes and Respond accordingly? ☐ Yes ☐ No ☐ N/A

Do you have any concerns regarding use of PEARR Tool? ☐ Yes ☐ No ☐ N/A

Your name/department/date: _____

Submit to [Insert Contact Information].

****NOT PART OF MEDICAL RECORD**** **Effective Date [Insert Date]**

PEARR Tool

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For more information, visit dignityhealth.org/human-trafficking-response

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PEARR Tool – Contact List of Resources and Reporting Agencies

Local, Regional, and State Resources/Agencies

County Child Welfare Agency:

County Welfare Agency for Vulnerable Adults:

Sexual Assault Response Team (SART) Center or Child Advocacy Center (CAC):

Local Law Enforcement Agency:

Local FBI Office:

Local DV/IPV Shelter – Program:

Local Runaway/Homeless Shelter:

Local Immigrant/Refugee Organization:

Local LGBTQ Resource/Program:

National Agencies, Advocates, Service Providers

National Human Trafficking Hotline: 1-888-373-7888 (888-3737-888)

National Domestic Violence Hotline: 1-800-799-SAFE (7233)

National Sexual Assault Hotline: 1-800-656-HOPE (4673)

National Teen Dating Abuse Hotline: 1-866-331-9474

National Runaway Safeline for Runaway and Homeless Youth: 1-800-RUNAWAY (786-2929)

StrongHearts Native Helpline: 1-844-7NATIVE (762-8483)

National Suicide Prevention Lifeline: 1-800-273-8255

Notes

The PEARR Tool was developed by Dignity Health, in partnership with HEAL Trafficking and Pacific Survivor Center, with support from Dignity Health Foundation.

Example HTR Task Force Checklist

I. Purpose

The purpose of this checklist is to provide guidance to Human Trafficking Response (HTR) Task Forces regarding implementation of the HTR Program.

II. Background

Due to the size of the [insert name] enterprise, responsibility of HTR Program implementation is delegated to HTR Task Forces with support and guidance from HTR Program Leadership. Contact [insert contact information for HTR Program Leadership] for additional information.

III. Checklist

This checklist provides HTR Task Forces with step-by-step action items for HTR Program implementation. The checklist is organized into the following sections:

- Identify Members and Establish Task Force Meetings
- Review and Implement Education
- Review and Implement Victim Response Procedures
- Debrief on Cases to Ensure Evidence-Based Best Practices
- Ensure Sustainability of the Program
- Strengthen the Community

The first section falls to the HTR Task Force Lead(s). The next three sections must be completed by all departments/disciplines represented on the Task Force. Responsibility of the final two sections falls on the Task Force as a whole, although Mission Integration, particularly Community Health, often takes the lead with action items in the final section. Task Force members should delegate tasks as needed; however, each member is ultimately responsible for completing tasks and ensuring sustainability in their represented department/discipline.

Identify Members and Establish Task Force Meetings
Task Force Lead(s) will identify Task Force members to represent stakeholder departments/ disciplines in the facility. **NOTE**: At least one representative for each department should have capacity to attend meetings and authority to make decisions on behalf of that department.
Task Force Lead(s) will design a schedule for ongoing (e.g., quarterly) Task Force meetings to ensure continued representation, accountability, and engagement with each department. Meeting goals: Discuss recent cases (or lack thereof), share cases reported in the local news, evaluate progress and needs for staff education/awareness, and provide updates on efforts, events, and accomplishments within the facility, community, and across the system.
IMPORTANT: If the facility is based in California and includes an emergency department or urgent care center, ensure that state-mandated posters have been posted in the appropriate languages in the emergency department or urgent care center lobby.[12]

Review and Implement Education
Each Task Force member will complete the following educational modules: • *Human Trafficking 101: Dispelling the Myths* • *A Trauma-Informed Approach to Patient Care and Services* • *PEARR Tool: Trauma-informed Victim Assistance in Health Care Settings* These Dignity Health modules are accessible at https://www.dignityhealth.org/hello-humankindness/human-trafficking.
Each Task Force member will ensure that these modules are assigned to all management and staff in their department/discipline accordingly.
Each Task Force member will work with the Education Department to ensure new staff hires/transfers are assigned/provided education accordingly. **NOTE**: It is recommended to have Education represented on the Task Force to assist in tasks related to education.
Each Task Force will ensure that hospital leadership is aware of the Program, including victim response policies/procedures and educational modules. **NOTE**: It is recommended to regularly update hospital leadership on the program's progress/activities.
Each Task Force will ensure representation on the Task Force for physicians, and this representative will help to ensure physicians are educated on the HTR Program, including victim response policies/procedures and educational modules.

Review and Implement Victim Response Procedures
Each Task Force Member will review the PEARR Tool, a procedure developed by Dignity Health, in partnership with HEAL Trafficking and Pacific Survivor Center. This tool describes how to **offer victim assistance** to patients in a trauma-informed manner **NOTE:** The PEARR Tool is a key component of Dignity Health's Abuse, Neglect, and Violence policy. Please ensure a similar policy is reviewed and approved for your facility.
Each Task Force will create and determine a process to maintain a list of public and private community agencies that offer support and services to victims/survivors of abuse, neglect, or violence, including victims/survivors of human trafficking.
Each Task Force will ensure that patient care staff have knowledge of and access to brochures and resources like the National Human Trafficking Hotline cards in English, Spanish, and other languages. These brochures and cards can be used to help educate patients about violence and can be offered to patients as a resource when appropriate.

Debrief on Cases to Ensure Evidence-Based Best Practices

The Abuse, Neglect, and Violence policy template from Dignity Health includes this step:

> *If there are concerns regarding procedural steps, particularly a variance or breakdown in policies or procedures, notify the Nurse Shift Manager/Shift Supervisor, or notify someone in a higher chain of command, **and complete an event report**. This includes a lack of response or negative response toward patients from private or public community agencies.*

As such, patient safety and clinical risk management personnel should be included on your Task Force to assist when debriefing difficult cases.

Each Task Force will consider ways to share evidence-based best practices with others in their local health care community. Example: Present at a local conference on human trafficking.

Ensure Sustainability of the Program

Each Task Force will design ongoing strategies to keep staff educated, engaged, and aware of the issue and programmatic goals (e.g., goals to identify victims/survivors and strengthen the community against human trafficking). Some examples from Dignity Health hospitals:

1. Sequoia Hospital held a day-long awareness event on-site with information tables, art exhibits, and vetted videos playing on a loop.
2. St. Bernardine Medical Center and Community Hospital San Bernardino both had a survivor speaker present at a staff Lunch & Learn.
3. The East Valley Foundation in Arizona provided scholarships for several members of staff from Mercy Gilbert Medical Center and Chandler Regional Medical Center to attend a large local conference on sex trafficking.
4. Chaplaincy at Methodist Hospital in Sacramento provided a reflection in the regional newsletter on February 8th, International Day of Prayer and Awareness Against Human Trafficking. Other notable dates: January is National Slavery and HT Prevention Month; January 11th is National HT Awareness Day, June 12th is World Day Against Child Labor, and July 30th is World Day Against Trafficking in Persons.

Strengthen the Community

Each Task Force will design or support vetted strategies to raise awareness about human trafficking in the community. Events to raise awareness about human trafficking can be coupled with strategies to raise funds. These funds can be used to support vetted local service providers/advocates and/or ongoing goals of the HTR Task Force/Program.

Example: Dignity Health's Mercy Medical Center Redding coordinated a film screening event in the community and raised funds for the local shelter.

Each Task Force will design or support strategies in the community to prevent human trafficking. See also the *Violence Prevention Resource Guide* developed by Catholic Health Initiatives (CHI) at https://www.catholichealthinitiatives.org/content/dam/chi-national/website/documents/CHI%20Violence%20Handbook%207-16a.pdf.

Each Task Force will engage with local first responders and other key stakeholders to assess education needs. Key stakeholders include mental health response teams, emergency medical technicians, child welfare agencies, law enforcement, and so on. It is important to ensure local first responders are educated on human trafficking, as well as trauma-informed practices. Example: Dignity Health's St. Mary Medical Center in Long Beach organized a training for staff and frontline responders in collaboration with a local survivor leader. **NOTE**: A Task Force Member in Education or Community Health should be identified to provide community education as needed/requested.
Each Task Force will engage with current efforts in the community to bring stakeholders together. Example: Join vetted local task forces or coalitions on human trafficking, ensure regular representation by your facility (e.g., by a Task Force member representing Community Health), and ensure regular feedback from this representative to Task Force Members. **NOTE**: If local efforts toward collaboration are lacking, then the Task Force will work to create a local collaborative network. Example: Dignity Health's Sierra Nevada Memorial Hospital helped to create a coalition in which community partners meet regularly.
Each Task Force will design strategies to engage employees and provide employees with updates and information about the Task Force and any local events as appropriate. Suggestion: Invite a Communications representative to join the Task Force and write newsletter articles about the Task Force's accomplishments and local events.
Each Task Force will work with their policy advocacy teams to support policy and advocacy priorities that address human trafficking.

PART IV: ADDITIONAL RESOURCES

- American Hospital Association: https://www.aha.org/combating-human-trafficking
- Catholic Health Initiatives Violence Prevention: https://www.catholichealthinitiatives.org/en/our-mission/advocacy/violence-prevention.html
- HEAL Trafficking: https://healtrafficking.org/
- Dignity Health Mercy Family Health Center HT Medical Safe Haven Shared Learnings Manual: https://dignityhlth.org/2Zs91sg
- National Human Trafficking Hotline: https://humantraffickinghotline.org/
- National Survivor Network: https://nationalsurvivornetwork.org/
- Office on Trafficking in Persons: https://www.acf.hhs.gov/otip
- SOAR to Health & Wellness Training Program: https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training
- Survivor Alliance: https://survivoralliance.org/

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