Safe Haven for Mental Health Services Project

Final Evaluation Report 2021

Grantee: Dignity Health Foundation
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Table of Contents

Acronyms

CARE	Consultation and Relational Empathy Measure
CBO	Community-based organization
DHMG	Dignity Health Medical Group
DOJ	Department of Justice
FQHC	Federally Qualified Health Clinic
GAD-7	Generalized Anxiety Disorder Assessment
HCCC	Hill Country Community Health Center
ICD-10	International Classification of Diseases
IRB	Institutional Review Board
LPC	LPC Consulting Associates, Inc.
MFHC	Mercy Family Health Center
MSH	Medical Save Haven
OVC	Office for Victims of Crime
PCL-5	PTSD Checklist for DSM-5
PHQ-9	Patient Health Questionnaire
TIC	Trauma Informed Care

Table of Figures and Tables

Figures

Tables

Executive Summary

Introduction

In October 2018, Dignity Health received funding from the Department of Justice, Office for Victims of Crime (DOJ OVC) to provide expanded mental health services to victims and survivors of human trafficking in their Medical Safe Haven clinic (MSH), located in Dignity Health Methodist Hospital's Family Medicine Residency Program in Sacramento. This funding also supported the expansion of the MSH model to two additional residency sites in California: Dignity Health Medical Group, Northridge Family Medicine Residency Program; and, Mercy Medical Center Redding, Family Practice Residency Program.

The MSH team provided training to support the expansion as well as training community service providers on human trafficking and services provided by the MSH. During the three years, the funding supported training a duplicated count of 3,637 people (they could attend more than one training), and the MSHs provided care to 359 patients (304 of whom were trafficked victims and survivors, plus 55 of their family members). These 359 patients received 3,200 hours of care, 1,625 hours provided by physicians and healthcare professionals and 1,606 provided by the Patient Advocates. The Patient Advocate is a highly trained staff person from a partnering community agency that works closely with the clinic staff, the trafficked patients, and partner agencies, providing the experience-based knowledge and the support for navigating health care, insurance, and social services. The number of hours the Patient Advocate spends supporting MSH patients speaks to the critical role of this position.

The funding supported a program evaluation, which was contracted to LPC Consulting Associates, Inc. This report is a summary of the evaluation findings for this project.

Evaluation Design

The MSH evaluation plan included both process and outcome measures to assess behavioral health outcomes for human trafficking victims and survivors as well as collected information on trainings and staff experiences to help with MSH program improvement. The design included both prospective and retrospective data from the three program areas:

- Victim/survivors accessing treatment at the MSH clinic (prospective and retrospective)
- Resident physicians and staff working in the MSH clinic (prospective and retrospective)
- Partnerships for a successful MSH (prospective)

Evaluation Limitations

There were several challenges that impacted the evaluation of the MSH, which limited the data collected. These challenges included:

- Delays in contracting and the IRB process
- The COVID-19 Pandemic and related stay-at-home-orders
- Consenting study participants
- Staffing changes
- Evaluation communication structure

Evaluation Findings

The evaluation findings included in this report is for data collected between April 2020, when IRB approval was received, through September 2021, when the grant ended. Redding and Northridge were added to the IRB during the final year (2020/21). Data collection in Sacramento started halfway through the grant period and was even later for the two added MSH sites (Northridge and Redding). There were two exceptions to this timeline: 1) data from 3rd year resident physicians, which included the classes of 2018 to 2021 for Sacramento and Redding and 2019 to 2021 for Redding, and 2) the retrospective portion of the study that included a chart review of MSH patients who participated in three or more visits since June 2016.

MSH Patients

Prospective Cohort

A total of 15 victim/survivor MSH patients consented to participate in the study, 12 from Sacramento, two from Redding, and one from Northridge. The age range of the victims/survivors was 18-49, with the mean age of 30.5. Patients reported exploitation starting as early as "a child" up to the age of 33, with half (6 of the 12 reporting) their exploitation started when they were a minor (under the age of 18). Most (13 or 93%) experienced sex trafficking and one reported labor trafficking (one was not reported). A summary of the findings included:

- **PTSD** As will be demonstrated by our data later in this report, the most prevalent domain of mental health disorders in the MSH patients is trauma-related disorders, including PTSD. For this reason, the MSH evaluation planning team selected the PTSD Checklist for DSM-5 ("PCL-5") as the primary tool for mental health assessment. The PCL-5 is a 20-item checklist intended to assess PTSD-related symptoms over the prior month, and can be used as both a screening tool as well as a marker for symptom improvement or worsening over time. The measure asks respondents to rate "In the past month, how much were you bothered by..." with responses ranging from "not at all" (0) to "extremely" (4). A total symptom severity score (range 0-80) was obtained by summing the scores of each individual response. A total score of 31-33 or higher suggests a diagnosis of PTSD (though this requires corroboration with a diagnostic interview). Scores lower than 31 may indicate the patient either has subthreshold symptoms of PTSD or does not, in fact, meet criteria for PTSD.
- **Linkages to Community Supports** The MSH Patient Advocates tracked referrals the MSH made to support victim/survivor needs and followed up on whether they connected with these resources. Of the 15 consenting patients, 14 had a least one referral, with 11 (79%) having a referral for more than one type of service. The service most referred to was specialty medical services, with 13 of the 14 (93%) referred, of which 11 followed through (an 85% follow through rate).
- **Patient Feedback** MSH patients completed a Consultation and Relational Empathy (CARE) Measure, a 5-question visual survey, to assess how patients felt during their visit. In total, 23 surveys were collected, and ratings were high; the highest-rated item asked, "How was your doctor at letting you tell your story," and received an average rating of 4.8 (a 5-point Likert scale, with 1=Not very good and 5=Excellent).
- **Patient Interviews** The evaluation included interviewing three MSH victims/survivors, and feedback was very positive. The patients shared the importance of a trauma informed, patient-centered approach to their care, and how the staff gave them a choice and involved them in decisions about their care.

Retrospective MSH Patient Cohort

A retrospective study of MSH patients was added to the evaluation plan later to better evaluate mental health outcomes. MSH staff reviewed 49 records from a random selection of 50 patients (one patient did not meet the criteria). For this sample,

- All but one patient had mental health addressed at some point in their care, and 84% had mental health addressed in at least 25% of their visits.
- 73% (26) received a prescription for medication to address mental health.
- 87% (41) had a diagnostic code for a Mental, Behavioral and Neurodevelopmental disorder (ICD-10 F code).
- 64% (30) had an ICD-10 code in Reaction to Severe Stress, and Adjustment Disorder (PTSD).

In addition, scores from two additional assessments that were used in response to treatment goals identified:

- Ten of the 12 PHQ-9 scores from the cohort indicated moderate to severe depression.
- All (100%) of the eight GAD-7 assessments indicated moderate to severe anxiety.

MSH Resident Physicians and Staff

Each year Dignity Health offered three MSH trainings to the new resident physician class, and to any other MSH staff who wanted to participate. Most of these trainings were in-person, but during the pandemic-related stay-at-home orders, some trainings were provided via Zoom. At the end of each of the MSH trainings, resident physicians completed anonymous paper or web-based subject specific post-survey with a retrospective pre-survey. The retrospective pre-survey questions asked trainees to *think back prior to the training* and select the best response for **before** attending the training. The post-survey questions asked participants to select a response for **now**, after participating in the training. These surveys included Likert-scale questions on knowledge, confidence, and satisfaction, specific to each training, which included:

- **Human Trafficking Medical Safe Haven**
- **Trauma Informed Care**
- **Patient Physician Encounters**

Knowledge increased for each of the subject specific questions, and the two statements with the largest increases were “Knows where to find resources for a human trafficking victim” and “An understanding of the role of the Patient Advocate in the MSH.” In opened-ended questions, training participants repeatedly shared wanting more information on resources for this population, ongoing trainings, and more experience working with trafficking victims/survivors.

The evaluation team conducted nine interviews with staff from the three MSH sites. These staff shared the rewarding nature of this work and the uniqueness of the MSH model, such as the length of time for the appointments and the important role of the advocate supporting not only the patient but supporting them while they work with victims/ survivors. They also shared the importance of a trauma informed "lens" when working with this population, and the need to be flexible and understanding because of the many other challenges they are dealing with while trying to manage their care. The interviewees also discussed the importance of ongoing trainings to support their work.

> "These experiences have been instrumental in developing my approach to patient care. I plan to start a Medical Safe Haven in my future practice and to teach the other physicians to care for these patients there. I discussed this with them prior to joining."
>
> - Resident Physician in Sacramento

Partnerships

Each of the three MSH communities has several organizations working with victims and survivors, and it is through these partnerships that most victims and survivors hear about and/or access MSH services. Because partnerships are integral to reaching victims and survivors, the evaluation included feedback from the MSH community partners. The questions were Likert-scale question with a chance to offer how each item could improve. A link to a web-based survey was emailed to 12 partners in September 2021, of which 11 (92%) responded.

- **MSH Working with Partners** On a scale of 1-5 (strongly disagree to strongly agree), partners rated the MSH highly, for an average rating of between 4.4-4.8. Feedback was positive, and several agencies mentioned that the response time was great, with the only suggestion being to offer an alternative number to contact on out-of-office emails.
- **MSH Pandemic-Related Questions** On a scale of 1-4 (rarely to always), partners were asked to respond to questions about MSH services during the first year of the pandemic. Scores ranged from 3.3-3.6, and no suggests were made for improvement.
- **Partners Working with the MSH** On a scale of 1-5 (strongly disagree to strongly agree), partners rated how their agency works with the MSH, with the partners rating themselves for an average of 4.2-4.8. Suggestions included more agency collaboration on victims/survivors they are both serving with the MSH.

Survey respondents shared the many ways that the MSH provides support for their roles as case managers, with the number one support being that they provide the mental and physical health treatment support their clients need, such as:

- Providing the care in a compassionate caring way,
- Developing treatment plans that work for the client, and
- Providing transportation via Circulation Lyft when needed.

The support with psychiatric services and helping with prescribed psychiatric medications, and how to navigate health insurance was also mentioned. One partner mentioned the emotional support that the Patient Advocate provides is truly valuable.

Conclusion

Based on what was learned from the evaluation, the evaluation team identified key findings, lessons learned and recommendations.

Key Outcomes

Due to the evaluation challenges related to patient data, the key findings are focused on resident physician training.

Human Trafficking Education Resident physicians participating in MSH trainings strongly agreed human trafficking education is an important component to resident physician training (4.8 on a 5-point scale).

Trauma Informed Care Resident physicians participating in MSH trainings strongly agreed trauma informed care is important when working with trafficking victims/survivors. (4.8 on a 5-point scale).

Empower Victims Resident physicians participating in MSH trainings "strongly agreed it is essential to empower adult human trafficking victims/survivors to make their own healthcare choices and to support their wishes, safety, and concern. (4.8 on a 5-point scale).

Human Trafficking Indicators Resident physicians participating in MSH trainings "extremely aware" of the potential physical indicators of trafficked victims/survivors. (4.8 on a 5-point scale).

Knowledge and Confidence There was a 75% increase in 3rd year resident physician's knowledge and confidence in working with trafficked victims and survivors.

Lessons Learned

Comprehensive Resident/Staff Training A comprehensive training program prepares resident physicians and staff in how to appropriately care for the human trafficked victim/survivor patient populations.

Patient Advocates The Patient Advocate role is vital to the MSH.

Extended Appointment Time Extended appointment time is key to working with this population.

Strong Community Partners It is important to have strong relationships with community partners working with this population. This creates a sustainable referral process and strengthens access to care.

Recommendations

Promote Local Resource List Resident physicians requested a list of local resources to have on hand to share with patients, which Dignity Health has created. A recommendation is to continue to promote and share this resource in trainings.

Create an Avenue for Patient/Client Communication Provide the opportunity for communication between MSH and partner agency on clients they are both serving.

The expansion of MSH model to two other California locations provided much needed supportive services to hundreds of trafficked patients. In addition, Dignity Health trained several cohorts of resident physicians, as well as other healthcare workers and community service organizations to raise awareness of human trafficking, and established and reinforced multiple community partnerships in the three locations. Findings from resident

surveys demonstrate increased knowledge and ability to provide patient-centered trauma informed care to not only MSH patients, but to patients they see outside of the MSH and with plans to use this approach throughout their careers. MSH staff expressed the deep impact of working in the MSH, and how it has impacted their practice and views of patients. While implementation of future MSH locations can provide the opportunity to quantitatively assess mental health outcomes of patients, the information shared by patients and staff during interviews and the evaluation findings in this report present a rich and compelling story of innovation and care. Although the evaluation had many challenges, the Medical Safe Haven continued to see patients and make a positive impact on trafficked patients, MSH resident physicians, MSH staff, and community partners

Introduction

Dignity Health Methodist Hospital's Family Medicine Residency Program in Sacramento is home of the Medical Safe Haven (MSH). This primary care medical clinic provides healthcare to trafficked victims and survivors with physicians and staff highly trained in human trafficking, trauma informed care, and a person-centered approach to healthcare. The MSH model includes three key components: 1) resident and staff training; 2) partnership building; and 3) a one stop shop approach to integrated victim and survivor healthcare. This model, piloted in 2016 in Sacramento, CA, included extensive training to clinic staff as well as the cultivation of strong multidisciplinary partnerships between the clinic and community-based organizations that serve trafficked victims and survivors.

In October 2018, Dignity Health received grant funding from the Department of Justice, Office for Victims of Crime (DOJ OVC) to provide expanded mental health services to victims and survivors of human trafficking and for the evaluation of the MSH. This funding also supported an expansion of the MSH model to two additional residency sites in California: Dignity Health Medical Group (DHMG), Northridge Family Medicine Residency Program; and, Mercy Medical Center Redding, Family Practice Residency Program.

Dignity Health contracted with LPC Consulting Associates, Inc. (LPC) in May 2019 to conduct a program evaluation of this effort. The prospective study design included both process and outcome measures to assess behavioral health outcomes for human trafficking victims and survivors as well as areas for program improvement at the MSH. The evaluation focuses on three areas: 1) victim/survivors, 2) resident physicians working in the MSH, and 3) multidisciplinary partnerships. The retrospective portion of the study included looking at changes in behavioral health conditions for patients who were not part of the prospective study and had three or more visits to the MSH. The funding also included program expansion to the two new resident training sites in Redding and Northridge, California. This report discusses findings from the MSH evaluation.

Description of the MSH

The MSH clinic is located in the family medicine residency training facilities at three Dignity Health locations (Sacramento, Northridge, and Redding) and provides comprehensive one-stop services for patients of all ages, including primary and urgent care, X-rays, labs, and access to hospital specialists. The MSH provides comprehensive, trauma informed longitudinal health services to persons who have experienced human trafficking.[1] MSH resident physicians participate in a fully developed curriculum which provides in-depth trainings to learn about human trafficking and delivering trauma informed and patient-centered care, and then how to incorporate these skills when seeing patients. The hope is that resident physicians will take these skills with them into future care, and this will positively impact the patient populations they serve.

> "I think it's been really good for the clinic; the other patients we serve tend to be an underserved and also traumatized population, even the ones who haven't been trafficked, so the Trauma Informed Care (TIC) approach has improved the care we provide to other patients as well; we follow the TIC approach and assume every patient we meet has been traumatized in some way, we start with that assumption and go from there."
>
> - Sacramento Physician

[1] HT MSH Program Manual, 2019 https://www.dignityhealth.org/sacramento/for-physicians/dignity-health-methodist-hospital-of-sacramento-family-medicine-residency-program/human-trafficking-safe-haven-clinic/medical-safe-haven-resources

The clinic structure in the MSH is unique to health clinics because appointments are given priority and extend a longer patient/physician encounter than traditional appointments, especially on the first few visits. An appointment with a victim/survivor is between 60-90 minutes, which supports the *commitment to trauma informed physician interactions and creates time to build trust and a sense of safety, time to review the patient's history and needs, time for Patient Advocate support, and time for the physician to explain labs and make referrals for services that will support full-scope wellness*.[2] The other valuable and innovative piece of the clinic structure is the embedded MSH Patient Advocate, a highly trained staff person that works closely with the clinic staff, the victim and survivor patients, and with the partner agencies, providing the knowledge of experience and the support to navigate health care, insurance, and social service resources. Developing and creating a strategic referral path by partnering with social service, law enforcement, and other organizations within the community is foundational to a coordinated and warm referral model of victims and survivor continuum of care.

> "The structure of our clinic allows for us to get these patients folded in for MSH intake appointments... Most often, they come to our clinic through community resource partners like WEAVE. Scheduled visits with these patients are primarily structured to enable the patient doing the talking and the provider doing the listening and because intakes are given and entire hour, patients are usually able to start opening up about their experiences. This is key to building trust. Constant contact within our outpatient clinic with our MSH patients from the time of their intake onwards regardless of their medical needs is key to continuing trust-building and key to normalizing medical visits for these patients who formerly feared medical attention due to its connotation with punitive measures."
>
> - Sacramento Resident Physician

Strong multidisciplinary partnerships with the local agencies that serve trafficked victims/survivors are an important component of the MSH. These partnerships are the main referral source to the MSH, as well as providing social and emotional support continuum of care for victims/survivors, as well as assists with follow through care and appointments. Receiving an exam can be retraumatizing to victims and survivors and having partner agencies that can vouch for the safety, kindness, and non-judgmental, trauma informed approach to care is key to patients' sense of empowerment coming to the clinic. This unique model of coordinated care creates equitable access and decreases barriers to victims and survivors receiving the vital healthcare they deserve.

MSH Sites

The MSH began in Sacramento, with funding later expanded to two more sites. The MSH clinics now include:

- **Dignity Health Methodist Hospital's Family Medicine Residency Program in Sacramento** The founding site, the Sacramento MSH is located in south Sacramento County, the capital of California. The Sacramento MSH program has in-house doctors in family medicine and psychiatry that provide health and behavioral support to patients. The integrated approach ensures that each MSH patient receives the full spectrum of primary care while also attending to the mental health disparities that victims and survivors often present with when establishing care at the MSH clinic. Dr. Ron Chambers, Program Director, Family Medicine Residency, at Methodist Hospital of Sacramento, piloted the MSH clinic as the first of its kind, with integrated medical and behavioral health services for individuals who are identified as victims and survivors of human trafficking. All physicians and staff at the MSH clinic receive extensive training on the MSH model and protocols needed to work with this population. In addition, processes and procedures are adapted to be able to respond to the unique needs of victims

[2] HT MSH Program Manual, 2019 https://www.dignityhealth.org/sacramento/for-physicians/dignity-health-methodist-hospital-of-sacramento-family-medicine-residency-program/human-trafficking-safe-haven-clinic/medical-safe-haven-resources

and create a healing environment. Full scope primary care along with trauma informed best practices makes this site the gold standard for a scalable model of care. Based upon this site's foundation, Jennifer Cox, Program Director, Medical Safe Haven, developed the program design that was then implemented within two additional residency programs aligned with DOJ funding. This site's leadership continues to champion all MSH programs within the organization.

- **Mercy Medical Center Redding, Family Practice Residency Program** The Redding MSH is located in rural northern California. The MSH program in Redding is a unique clinical partnership between the Mercy Family Health Center (MFHC) and Hill Country Community Health Center (HCCC). HCCC is a Federally Qualified Health Clinic (FQHC) specializing in 24-hour behavioral health crisis response and ongoing mental health treatment and management. HCCC is a partner clinic providing training for resident physicians from MFHC. Additionally, the core faculty from HCCC provides precepting support at the MFHC to instruct resident physicians on providing MSH patient encounters. This partnership model provides enhanced and increased access to mental health services for MSH patients.
- **Dignity Health Medical Group (DHMG), Northridge Family Medicine Residency Program** The Northridge MSH is located on the outskirts of Los Angeles in southern California. The MSH program in Northridge is the third replicated MSH within CommonSpirit Health.[3] This unique location creates an equitable access model of care for identified victims and survivors of human trafficking within the greater Los Angeles County region. Full scope primary care along with integrated behavioral health services provide a safe space for patients to heal and elevate a trauma informed response for all patient populations served by this compassionate and highly trained team.

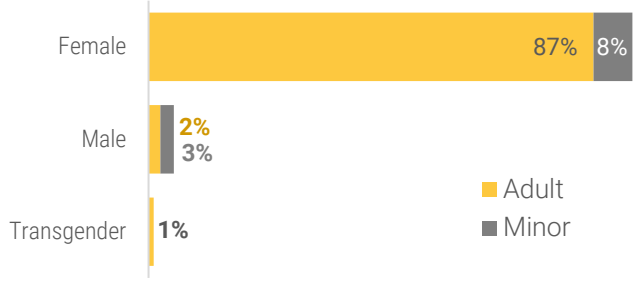
Data collected from these three sites are presented in aggregate in this evaluation report.

Summary of Services During Grant Period

Patient Care

During the three years of funding, the MSH sites provided trauma informed victim-centered care to 359 patients, of whom 304 were trafficked victims and survivors and 55 were family members of the victim/survivor. Most of the MSH patients were female (286 or 94%), of whom 263 were adults (87%) and 23 minors (8%). The clinics saw 15 (5%) male trafficked victims (7 adults and 8 minors) and 3 (1%) transgender adults (see **Figure 1**).

Figure 1 | Gender of MSH Patients n=304



[3] CommonSpirit was formed in 2019 through the alignment of Catholic Health Initiatives (CHI) and Dignity Health

Of the types of trafficking, sex trafficking was the primary, with 239 victim/survivors currently or historically involved in this form of trafficking (79%). (Figure 2.) A total of 17 patients (6%) were or had been involved in labor trafficking and a few (5 or 2%) experienced both forms of trafficking. The type of trafficking was unknown for 43 patients (14%).

Figure 2 | Type of trafficking, n=304

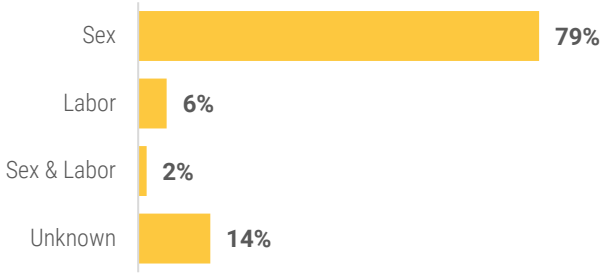


Table 1 displays the number of MSH staff hours provided by type of service for the 304 trafficked patients and their 55 family members. During the three years of funding, MSH staff provided a total of 3,200 hours working with the 359 trafficked patients and their family members. Physicians and healthcare professionals provided a total of 1,595 hours: 1,515 hours for medical care and 80 hours for mental health care. Patient advocates provided a total of 1,606 hours of other services that are important to engaging patients in their healthcare. This speaks to the critical role of the Patient Advocate in supporting MSH patients to engage in their care. The types of support provided included: ongoing case management for appointments and referrals (1,162 hours), emotional and moral support during visits (181 hours), arranging transportation for appointments (137 hours), providing help with social services and insurance (34 hours), helping connect patients to basic needs (30 hours), such as housing, safety planning, and personal items, and helping patients connect with substance use treatment (23 hours) and dental services (8 hours).

Table 1 | Types of Services Provided to MSH Patients

Patient Advocate	Medical staff	Type of Service	Total # of hours
	●	Medical (Emergency/Long-Term)	1,515.00
●		Ongoing Case Management	1,162.00
●		Emotional/Moral Support (Non-Mental Health)	180.50
●		Transportation	137.25
	●	Mental Health and Treatment (Emergency/Long-Term)	79.75
●		Social Service Advocacy and Explanation of Benefits/Entitlements/Availability	34.25
●		Client Intake	26.50
●		Substance Abuse Treatment	22.50
●		Housing/Shelter Advocacy	15.75
●		Protection/Safety Planning	9.25
●		Dental (Emergency/Long-Term)	7.75
●		Personal Items (Food/Clothing/Personal Hygiene)	4.75
●		Crisis Intervention or 24-Hour Hotline	1.75
●		Interpreter/Translator	1.50
●		Other Service	1.25
●		Client Orientation	0.50
		Total hours	**3,200.25**

Training

The MSH clinics are housed in family medicine residency training facilities. Resident physicians working in these clinics participate in trainings designed to teach them about human trafficking, trauma informed care, and how to work with tracked victims/survivors. In addition, Dignity Health provides training to other healthcare workers and community service organizations to raise awareness of human trafficking, teach them how to identify and respond to victims/survivors, and educate them about the MSH.

Table 2 displays the duplicated (people can attend several trainings) number of people trained (3,637) by industry, and Table 3 displays the duplicated number of people trained by topic area.

Table 2 | Duplicated # of People Trained by Industry

	Duplicate # of participants
Medical/Public Health Providers	2,851
Social Services Providers	346
Schools/Educational Institutions	105
Victim Service Providers	100
Federal Agencies Other Than Law Enforcement	50
Immigrant/Ethnic Service Providers	50
State/Local Government Agencies Other Than Law Enforcement	50
Housing/Shelter	25
Legal Providers	25
Mental Health/Substance Abuse Providers	20
Prosecutors	10
Federal Law Enforcement	5

Table 3 | Duplicated # of People Trained by Training Topic

	Duplicate # of participants
Definition of Human Trafficking Victims	3,472
Identification of Human Trafficking Victims	3,472
Health and Trauma Consequences of Human Trafficking	3,460
Techniques for Screening/Interviewing Human Trafficking Victims	3,438
Services Available to Victims of Human Trafficking	3,417
Risk Factors for Human Trafficking	3,413
Culturally and Linguistically Appropriate Services for Human Trafficking Victims	3,412
Local/Regional Dimensions of Human Trafficking	3,409
Global Dimensions of Human Trafficking	3,390
Collaboration and Building Multidisciplinary Relationships	3,341
Procedures for Reporting Human Trafficking Victims	3,322
Legal Assistance for Human Trafficking Victims	2,949
Activism on Human Trafficking	343
Volunteer Training	150
Corporate Social Responsibility	8

MSH Program Evaluation

The evaluation of the MSH was guided by four main program objectives identified in the funding proposal.

Program Objectives

1. Provide mental health services integrated with medical care and substance use treatment using victim-centered and trauma informed service delivery.
2. Work in collaboration with federal, state, and local law enforcement, local service providers, and community-and faith-based organizations to ensure trafficked victims are identified and referred for appropriate services.
3. Conduct training and public awareness activities for professionals and community members to improve their knowledge of human trafficking and their ability to identify and respond to victims.
4. Expand the Medical Safe Haven to two more Dignity Health resident training programs located at Dignity Health Medical Group, Northridge Family Medicine Residency Program; and, Mercy Medical Center Redding, Family Practice Residency Program.

Planning for the evaluation was a collaborative process and involved LPC staff participating in a series of meetings with MSH administrative and medical staff to learn about the MSH as well as hear concerns, questions, and recommendations for the evaluation. LPC used the following process for developing the evaluation plan.

Group Logic Model Exercise	LPC staff participated in a series of meetings with MSH administrative and medical staff, as well as facilitated a group logic model exercise to help learn about the MSH. (June 2019)
Research Questions Process & Outcome Measures	Information learned from the meetings and group logic model process guided the development of the research questions and identified process and outcome measures. (Sept. 2019)
Data Collection Tools and Assessments	LPC identified and/or created assessments and data collection tools to (1) help clinic staff with ongoing quality improvement & clinic processes and (2) provide tools for patient treatment while fulfilling the needs of the evaluation. (Sept. 2019)
Stakeholder Feedback	The evaluation plan was presented and discussed at the MSH Annual Meeting which included community partners who refer trafficked victims and survivors to the MSH as well as mental health providers who serve these patients. (January 2020)
Evaluation Plan & IRB Proposal	The above steps fed into the development of the evaluation plan and Institutional Review Board (IRB) proposal. MSH staff were provided the opportunity to provide feedback to the evaluation plan, assessment & data collection tools (submitted Feb. 2020, IRB approved April 2020).

The research questions that guided the evaluation plan were:

Victims/Survivors

- What are the characteristics of those referred?
- To what extent does the survivor establish MSH as their medical home?
- What are some of the behavioral health outcomes for survivors who are treated at MSH?

Resident Physician Training

- What are MSH resident physicians gaining from attending the MSH trainings?
- How do MSH resident physicians share information about Trauma Informed Care (TIC) and the MSH model with their peers and colleagues?
- How have MSH resident physicians applied what they learned about TIC, and how do they plan to use these skills in their future medical practice?

Partnerships

- Who is referring prospective patients to the MSH?
- What additional resources do community-based partners provide to MSH patients?

The MSH evaluation included both process and outcome measures to assess behavioral health outcomes for human trafficking victims and survivors as well as collected information on trainings and staff experiences to help with MSH program improvement. The three program areas are:

- Victim/survivors accessing treatment at the MSH clinic (prospective and retrospective)
- Resident physicians and staff working in the MSH clinic (prospective and retrospective)
- Partnerships for a successful MSH (prospective)

The design includes both prospective and retrospective data, including prospective data from MSH patients and resident trainings and a retrospective data from a sample of MSH patients and recently completed 3rd year resident physicians (classes of 2018 and 2019).

Evaluation Limitations

There were several challenges that impacted the evaluation of the MSH, which limited data collection. These challenges included:

Delays in Contracting and the IRB process

The contract for the evaluation was signed April 30, 2019, which meant work on the evaluation did not begin until May 1, 2019, eight months into the project. Once approved, the evaluation staff had to learn about the proposed work, develop data collection tools, and develop an evaluation plan. Due to the nature of this study, the evaluation required IRB approval, which was completed in January 2020 and approved in April 2020, one and a half years into the three-year project and at the same time that the COVID-19 pandemic hit California, along with related public health orders. Due to the late start, challenges collecting consent, and the pandemic, victim/survivor data was limited.

Pandemic

Like most things in the world, the COVID-19 pandemic created several challenges that affected the evaluation of the MSH. Some of these challenges included:

- A decrease in referrals to the MSH due to a reduced number of people seeking care and partners decreasing their services due to the pandemic Executive Order to stay at home.
- MSH clinics having to innovate their model to include telehealth appointments for patients who did not want or need in-person care.
- Developing an appropriate study consent process for patients participating in telehealth appointments.
- Submitting required and time-intensive IRB modifications to include changes in data collection related to telehealth.

Consenting Patients

In general, victims and survivors are a challenging population to gain study consent. This population has a history of being repeatedly violated, and they often have a hard time with trust. Just receiving a medical exam can be retraumatizing or they may be in crisis at the time of the initial visit. Trying to consent someone into the evaluation in these circumstances proved very challenging, and few consented. This, coupled with the study excluding victim/survivor minors (those under the age of 18), limited participation in the evaluation. Of the 359 unique clients who received care served during the funding, 15 (4%) consented to participate in the evaluation. This challenge was not unique to the MSH. Feedback from other DOJ OVC grantees was that they also faced similar challenges trying to consent patients early into care when they suffered from trauma. To address this, the IRB was modified to include some retrospective data to help address the research question "What are some of the behavioral health outcomes for survivors who are treated at MSH?"

Staffing Changes

The Patient Advocate plays a key role in the MSH. This person is the bridge between the MSH clinic, the patient, and the partner agencies. They need the skills to promote communication among all three, demonstrate care and empathy, promote the trust needed to maintain relationships among the clinic, patients, and partners, and understand the requirements of a research study. Both Sacramento and Northridge lost their Patient Advocates during the third year of the grant, which created delays and challenges for the evaluation. The COVID-19 pandemic also created challenges with hiring for this key role. Interviewing via conference calls limits the ability to really get to know or "get a read" on candidates, to assess whether they have the skill set and personality for this vital role. Then, once this role was filled, there were further delays while they were trained to understand the MSH processes and research protocols.

These staffing changes impacted data collection. The Patient Advocate is the person responsible for explaining the evaluation and asking them to consent to participate as well as make sure all baseline and follow-up data is collected from victims/survivors. Often all the data was not collected at the first visit due to patient circumstances, which is understandable given the history of the victims/survivors, but then it was reported that these forms were overlooked at the follow-up visit. In addition, follow-up data was very limited, either due to the patient not returning or the follow-up measures being overlooked. There were two pieces of follow-up data, the PTSD Checklist and referral follow-up. The victims/survivor outcome objective was a decrease in their PTSD Checklist assessment score, with the baseline completed at intake and then re-administered at the discretion of the MSH treatment team to measure change in PTSD symptomatology. The change in severity score from this assessment was the initial behavioral health outcome measure identified for the evaluation, but the follow-up assessments were very limited (2 patients). To try and address this, the Research Coordinator trained MSH staff and the Patient Advocate on data collection processes several times and developed data collection flow-charts and checklists, but still collecting this data proved challenging.

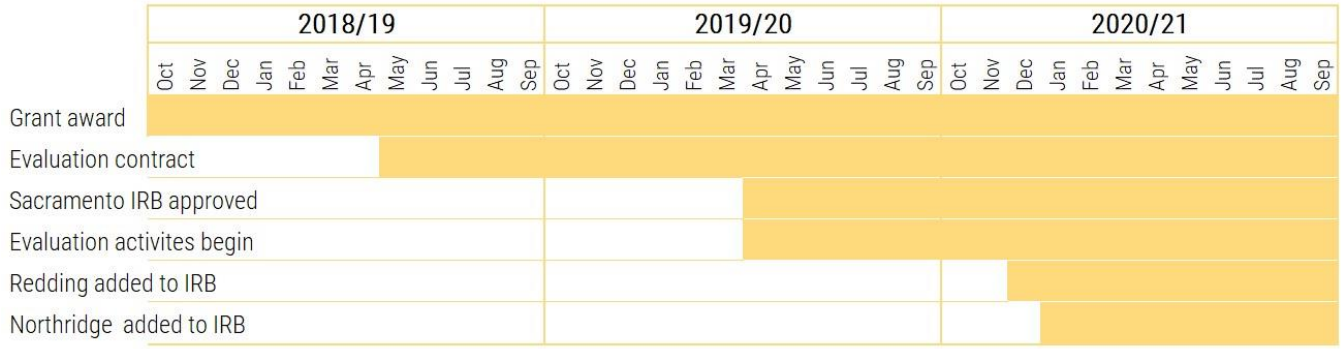
Evaluation Communication Structure

Due to the IRB and the structure of Dignity Health, the evaluator role was truly external. Evaluation related communication went through the Research Coordinator who then communicated with staff. This process is more common for research but not for program evaluations. Program evaluators are usually more in touch with the line staff to understand the challenges and modify the process to help "make things work." The distanced position of the evaluator left a void of really being able to understand what is happening at the MSH and created delays in communication. To address this, the evaluator and Research Coordinator had monthly check-in meetings, which helped some, but still did not allow the program evaluation to have the full understanding of the processes, and the IRB limited modifications to address challenges.

Evaluation Findings

The evaluation findings presented in this report include data collected between April 2020, when IRB approval was received, through September 2021, when the funding ended. Redding and Northridge were added to the IRB during the final year (2020/21). **Figure 3** displays the varying timelines for the evaluation contract, and IRB approvals for the MSH sites. Data collection in Sacramento started halfway through the grant period and was even later for the two added MSH sites (Northridge and Redding). There were two exceptions to this timeline: 1) data from 3rd year resident physicians, which included the classes that completed residency between 2018 to 2021 for Sacramento and Redding and 2019 to 2021 for Redding, and 2) the retrospective portion of the study that included a chart review of 50 MSH patients who participated in three or more visits between June 2016 and September 30, 2021.

Figure 3 | Data Collection Timeline



Human Trafficking Victims and Survivors

Human trafficking is defined as the use of force, fraud, or coercion to obtain some type of labor or commercial sex act, and victims/survivors can be of any age or gender.[4] Most of the victims/survivors who seek medical care in the MSH clinic are referred by a partner community-based organization (CBO) that already works with victim/survivors. The victim/survivor data for the prospective study included consented new MSH patients (i.e. not existing patients), who were at least 18 years old seeking care in Sacramento, Redding, or Northridge MSH clinics. Exceptions were for existing MSH patients (≥18 years old) who consented to participate in an interview.

Prospective MSH Patient Cohort

The evaluation plan included a universal MSH Referral/Intake Form completed by CBOs referring to the MSH. This referral form collected basic contact information and other information to help clinic staff with the first visit, such as trauma triggers, recent visits to Emergency Departments, current medications, type of trafficking, initial age of exploitation, foster system involvement, and goals for the appointment. This data provided the following description of program participants.

A total of 15 victim/survivor MSH patients consented to participate in the study, 12 from Sacramento, two from Redding, and one from Northridge. Characteristics of the victims/survivors who consented included:

- **Age** The age range of the victims/survivors was 18 to 49, with a mean age of 30.5.
- **Age of Exploitation** Twelve of the participants reported the age when their exploitation began, ranging from "child" to age 33, with half (6 or 50%) reporting it began when they were a minor (< 18).
- **Type of trafficking** Thirteen (93%) of were victims of sex trafficking, one labor trafficking, and one unknown.
- **Foster care** Seven (47%) reported involvement in the foster care system.
- **Children** Four (27%) reported having children in need of care.
- **Emergency Department Visits** Seven (50%) reported visiting an emergency department in the previous 12 months, with the number of visits ranging from one to three (four reported one visit, three reported three visits).
- **Appointment goals** The main appointment goal for all study participants (100%) was to establish care, but almost half (47%) needed medication, one-third (33%) needed treatment for a sexually transmitted infection (STI), and over one-quarter needed mental health services (see Table 4).

Table 4 | Initial Appointment Goals

Appointment Goals	#	%
Establish care	15	100%
Medication	7	47%
STI	5	33%
Mental health	4	27%
Pregnancy	3	20%
Injury	3	20%
Other	3	20%

[4] US Department of Health & Human Services, Office on Trafficking in Persons, Human Trafficking Fact Sheet

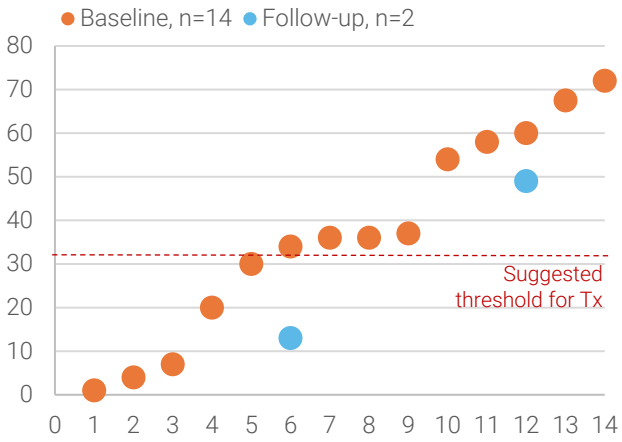
PTSD

The PTSD Checklist for DSM-5 (PCL-5) is a 20-item PTSD screening tool that the MSH evaluation planning team selected to assess mental health outcomes in program participants, as well as a tool in identifying patients in need of behavioral health services and a possible consultation with the psychiatrist. The PCL-5 is intended to assess patient symptoms in the past month. The measure asks respondents to rate *"In the past month, how much were you bothered by…"* with responses ranging from "not at all" (0) to "extremely" (4). A total symptom severity score (range 0-80) was obtained by summing the scores of the 20 items. A total score of 31-33 or higher suggests a diagnosis of PTSD. Scores lower than 31 may indicate the patient either has subthreshold symptoms of PTSD or does not meet criteria for PTSD.[5]

The assessment was to be completed during the first MSH appointment and re-administered at the discretion of the MSH treatment team to measure change in PTSD symptomatology. The change in the PCL-5 score was used as the behavioral health outcome measure for the evaluation. This checklist was available in English, Spanish and Chinese.

A total of 14 baseline PCL-5 assessments were completed on the 15 consented patients, and two patients had a follow-up PCL-5 assessment. The baseline scores ranged from 1 to 72, with a mean score of 36.9 and a median score of 36, which shows that nine (64%) of the victims/survivors completing the baseline assessment met the threshold suggesting they might benefit from PTSD treatment. The two follow-up assessments indicated a decrease in PTSD symptoms, with one score decreasing from 34 to 13, and the other decreasing from 60 to 49. The limited dataset prevented further analysis. (See **Figure 4** for all assessment scores)

Figure 4 | PCL-5 Scores, baseline and follow-up

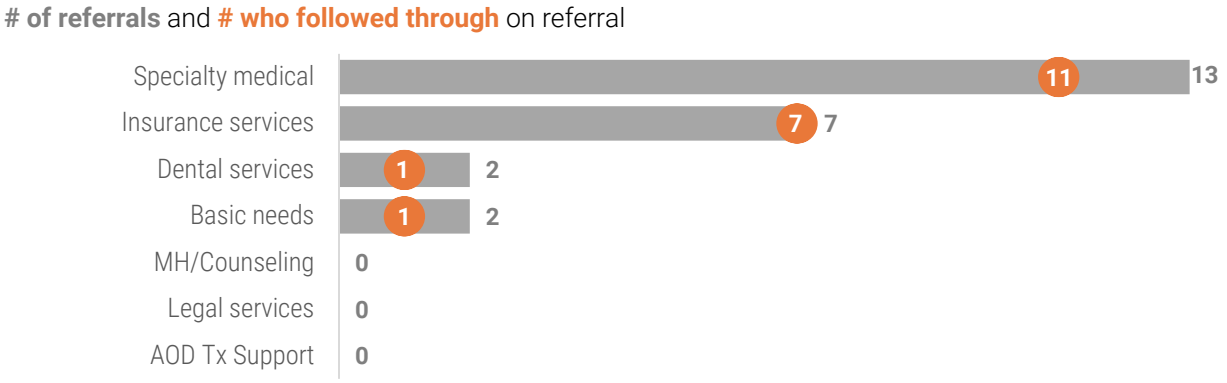


Linkages to Community Support

As part of victim/survivor support, the MSH Patient Advocate tracked the types of referrals MSH staff made to support victim/survivor needs, and then followed up on whether they followed through with the referral on return visits. Of the 15 consented patients, 14 had a least one referral, with 11 (79%) having a referral for more than one type of service (7 had one referral, 5 had two referrals, and 2 had three referrals). The service most referred to was specialty medical services, with 13 of the 14 (93%) referred, of which 11 followed through (an 85% follow through rate). The second most referred to service was insurance services, with seven patients referred (50%) with all seven (100%) following through on the referral. See **Figure 5** for more details on referrals and follow-through.

[5] Using the PTSD Checklist for DSM-5 (PCL-5), National Center for PTSD. www.ptsd.va.gov

Figure 5 | Referrals by Type and Follow-through



Patient Feedback on MSH

The key component to the MSH clinic is the trauma informed and a victim-centered approach of the MSH staff. To assess how patients felt during their visit, consented MSH patients completed a Consultation and Relational Empathy (CARE) Measure,[6] a 5-question visual survey at the end of each visit that they could put into a secure drop-box. This survey was available in English, Spanish, and Chinese in a paper format and as an internet-based survey. This short questionnaire assesses empathy in the context of the doctor/patient relationship, using a 5-point Likert scale, with 1=Not very good and 5=Excellent. In total, 23 surveys were collected, 16 from Sacramento, six from Redding, and one from Northridge. All ratings were high, with the highest rating for "How was your doctor at letting you tell your story" having an average rating of 4.8. **Figure 6** displays the average ratings for the five questions on the CARE measure. The high ratings on these surveys demonstrates the value of a trauma-informed team creating an environment of trust, voice and choice.

Figure 6 | CARE Measure Findings, n=23

[6] Consultation and Relational Empathy (CARE) Measure, Departments of General Practice in Glasgow University and Edinburgh University, https://caremeasure.stir.ac.uk

Victim/Survivor Interviews

To learn more about victim and survivors' experiences in the MSH, program evaluation staff conducted interviews with three current MSH patients (2 from Sacramento, 1 from Northridge), whose length of MSH care ranged from nine months to many years (from approximately 6 visits to "too many visits to count"). Interviewees were offered an incentive to participate, with interviews completed over Zoom with a member of the evaluation team facilitating the discussion and another member transcribing the conversation. The interview protocol consisted of 12 questions to learn about their overall experience with the MSH clinic and clinic staff.

General Perceptions

All three participants spoke highly of the care they received through the MSH clinics.

> They're very kind and caring; very effective with coming up with the best solutions for me; and when I had my children, [solutions for] my children also; it's been great care.

Participants conveyed the stark differences between the care they received in previous clinics and the care received in the MSH Clinics, citing negative experiences with previous healthcare providers.

> I have mental health issues I deal with and what I've found prior to MSH is that doctors just want to give me meds and are not including me in my own health.

> The other doctors, even though I was 13 when I was turned out [to trafficking], thought I was a prostitute, a criminal, it didn't matter. Even when I went to them as a kid, or as an adult, they considered me a criminal, so I never felt seen, like, no one cared about this baby prostitute.

Strengths of MSH Model

Patients shared the aspects of their experiences with MSH that contributed to their satisfaction with the clinic, doctors, and staff they interacted with.

Trauma Informed Care Model

Knowledge of Trafficking and Trauma All three patients commented on how doctors' knowledge of trafficking and trauma improved their experience. The patients shared how doctors listened and heard their fear of being examined, and asked permission before touching them, and they had an awareness about what can be retraumatizing for victim/survivors of trafficking, and were thoughtful in how they spoke and asked questions.

> I feel like she [the doctor] understands about trauma and trafficking. I've been with some good major healthcare systems in the past, and if I said I was trafficked or abused or anything, the doctor looked horrified, they looked traumatized; that's the worst, when I feel like I've traumatized them – and then they try to go through my family history, when my family trafficked me… so they ask did your mom have this? did your dad have this? It's like, I just told you my family members trafficked me… like you might as well think I was an orphan, because I don't have that information- it's really traumatizing when they probe like that. When I told her [the MSH doctor] that [about my trafficking], she didn't keep probing, she didn't look traumatized.

> She knows her patients are traumatized; like, telling me when she's going to touch me, asking if she can put the stethoscope in my shirt. I have a lot of trauma, so if [doctors] don't tell me [what they're doing], sometimes I jump. And the doctor telling me that I can tell her to stop, it's made a big difference.

Extra Time for Appointments The importance of having more time allocated to doctor visits in the MSH clinic was mentioned as very helpful to feeling comfortable and safe, that it gives the patient and doctor more opportunity to build a relationship.

> She makes extra time because she knows I'll be nervous about things and takes time to listen. Normally [doctor's appointments] are 10 minutes and they don't care; they don't care about what I think, I'm treated like a number.

Person-Centered Care

Listening to Patients Throughout the interviews, patients emphasized feeling that MSH physicians consistently take time to listen to patient needs and really hear what they have to say, as well as respect patient's beliefs.

> Even with my baby (I'm super paranoid about my son), it sounded like he was wheezy, and I would come in and they would check him for asthma. Even when they knew their diagnosis was sound, for the sake of giving me peace of mind they would give me other opinions.

> I'm super religious, I'm always talking about Jesus as the solution; like I need to pray and go to church; and I find in a lot of places when you talk about your faith they get uncomfortable, but they [MSH doctors] don't do that – they just say, "you are absolutely right, you know what works for you"… I feel like they really respect my religious freedom.

Prioritizing Patient's Choice A consistent theme across the interviews was patients valuing that MSH physicians actively offer space for patients to make decisions about their own health, and respecting that patient know their own bodies best.

> I've had [other] pretty bad experiences with doctors, like lawsuit issues; I would get really badly sick and I would rather die than go to the doctor; I felt like they didn't see me as a patient; they tried to make it seem like because of my mental health issues I couldn't make my own decisions. Before the [MSH] clinic I didn't realize I had a voice; and when they presented me with the treatment plans, that was the first time I felt like I had a choice.

> I think they take my values seriously. I battle with mental health, but I don't like meds. A big trauma for me in my childhood was being overmedicated. They're good at helping me balance coping skills and medications, so I only take one pill. When I first started [at the MSH], I was really chemically imbalanced, so I did need more medication, but there was never pressure. I tell them I how I feel, and they come up with a couple plans, they tell me the pros and cons [of each plan], and it's up to me to decide.

Involving Patients in Care Plan Patients were asked whether they felt their doctors involved them in their care plan, and if so, whether this was a new experience for them. All patients felt very involved in their care plans and shared that this was a new experience for them.

> … it was a new experience, it made me feel validated. It's a little emotional. Having healthcare is important, especially when you have mental health issues and trauma. Having a healthy relationship with a doctor that you feel comfortable to go to when you need help is so important.

> I've told [my doctor] that I needed help because I felt very overwhelmed with trauma symptoms, so she started me on something smaller. Then, I said I needed something stronger to handle my stronger symptoms and she gave me something stronger. So, I felt like she really listened to me. She does seem cautious prescribing things, but that's fine, I feel like she's being sensitive, conscientious.

Advocates for their own health Listening to patient's needs, prioritizing patient's choice, and involving patients in their care plans all contribute to making patients feel they can advocate for their own health.

> This clinic allows me space to be able to [advocate for my own health]—it's not quick visits when they tap on your knee, they have conversations and if I have a concern it's listened to. Anything I've needed, my needs have been met. If I'm saying something is wrong, they'll investigate further, they allow space for me.

Holistic Care

Patient Advocate All three participants spoke highly of their Patient Advocate and the supports they provided to them for health care, basic needs, and community resources.

> I loved having a Patient Advocate…it felt like VIP treatment for me. Sometimes I'm bad with communicating, but I've never missed an appointment since they will reach out to me, check-in on me… It's more than an advocate, they're really effective.

Connection to Services Patients commented on how connected the MSH Clinic staff are to services in the community, including both the Patient Advocates and Physicians. The strong connections to other services and agencies provide a greater network of supports for patients to access.

> They are so plugged in. They saved my life when I was going through domestic violence and they connected me to WEAVE. They've always been there for me; they've become my family; when I first started coming there [to the MSH] I thought I was a nobody, scum of the earth, and they believed in me before I believed in me.

Areas of Improvement

Even though most of the discussion focused on the strengths of the MSH, the patients did have some suggestions to help improve the overall experience. These included:

Scheduling There were two suggestions around scheduling, in particular when scheduling with a specialist or referring to another department. The first suggestion was offering multiple appointment times for patients to choose from, as opposed to offering a single appointment time and leaving it up to the patient to call to reschedule if that time does not work for their schedule. The second suggestion was making more same-day appointments available, since it can be challenging to get an appointment quickly, which might lead to a patient needing to access urgent care or an emergency department.

> Sometimes they tell you that you need to come in at whatever date on 10am, and I have to work -- I can't just come in when you say, it needs to be a time I can take off of work, because it's really far for me to drive… the only thing they tell me is if it's not a time you can make, call and reschedule – but it would be easier to schedule it from the beginning.

> Sometimes you really need to be seen like right now, and sometimes I feel like I have to jump through hoops [to get a visit] … I can't afford to go to the emergency room, so sometimes I'll just stay here and grit through it… And urgent cares are really bad, I wouldn't go there for something internal like this… It's traumatic even

> for me to think about [my MSH doctor] examining me, so I would have to be dying to go to the emergency department for them to examine me.

Exit Procedures A patient expressed confusion about the exit procedures at the end of appointments. She felt that the procedures had not been communicated to her, so she didn't know if another healthcare worker or staff person was coming back after the examination when the doctor left the room or if she was supposed to leave. It was not clearly explained to her that the appointment was over and what the next steps were. Since the procedures were unclear, this patient just left.

Unique Circumstances One patient shared that she uses her experience as a trafficking survivor to advocate for other victim/survivors through her work with a nonprofit. While she can advocate for others, it is much more difficult to advocate for herself, and sometimes this is not understood at the clinic.

> They assume I don't need their help navigating the system… I think I slip between the cracks because I am functional, I put up a good mask to the world, but by myself I am really having a hard time.

Changing Doctors Since MSH is a residency program, doctors typically only spend three years at the clinic, aside from the doctors that oversee the clinic. One patient expressed that this can be difficult for her, since she builds strong relationships with her doctors and grows to deeply trust them, and change is hard. However, this patient recognized that this is the nature of a residency program, and the MSH is a learning experience for new doctors.

Summary

The patients interviewed generally expressed positive, person-centered, trauma informed experiences at the MSH clinic. These positive experiences were markedly different from previous experiences with health clinics, where patients expressed feeling unheard and even traumatized by healthcare professionals outside of the MSH. The MSH patients felt like they were partners with their doctors in developing their care plans, with some even feeling that this was the first time they had control over their medical decisions.

> "They're more than a primary care doctor for me, they're an everything doctor. They're like family."
>
> - MSH Patient

Retrospective MSH Patient Cohort

Due to the prospective study including a limited number of consented patients, a retrospective study was added to the evaluation that included data from 50 randomly selected MSH patients who had three or more MSH visits since June 1, 2016. The evaluation team provided the selected patient numbers and the Research Coordinator pulled data from medical records on 49 of the 50 patients that were randomly selected (one patient did not meet the criteria). The data included:

- Total number of MSH visits
- Length of time with MSH
- Number of visits that addressed mental health
- Number of patients with a prescription for mental health medication
- Depression and anxiety scores
- ICD-10 diagnosis codes
- Noted mental health changes from one visit to the next

This section of the report discusses these findings.

MSH Visits

The retrospective cohort included 49 patients that visited the MSH clinic from three to 64 times from June 1, 2016 to September 30, 2021. The average number of visits was 12.4 with a median of nine visits. The average number of months as an MSH patient was 12.8, with a median of nine months and a range of one to 34 months. The average number of patient visits addressing mental health was eight, with a median of four and a range from 0-56 visits (see Table 5).

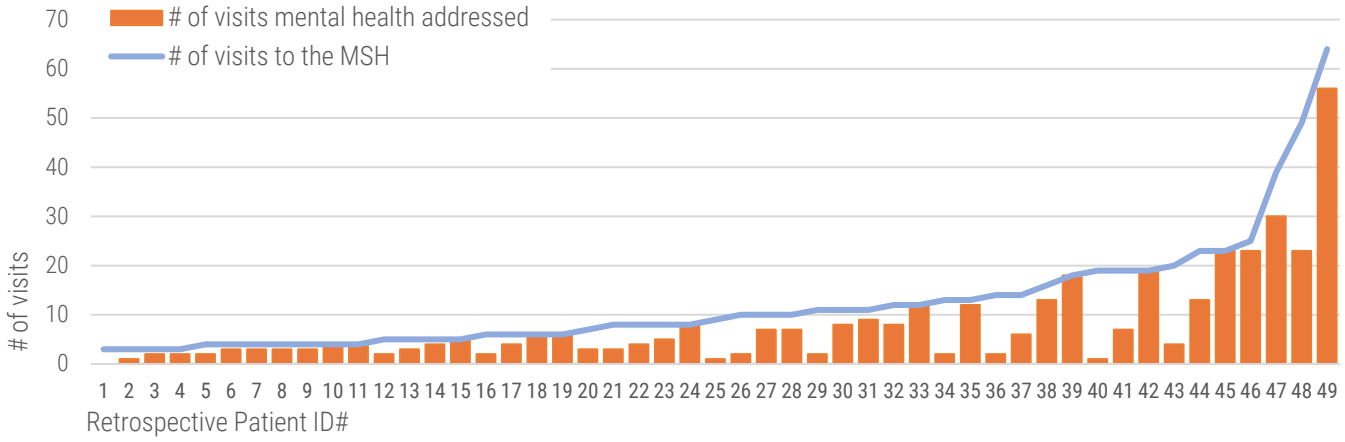
Table 5 | # of visits & months established with MSH

	# Visits	# MH visits	# Months
Range	3-64 visits	0-56 visits	1-34 months
Average	12.4 visits	8.0 visits	12.8 months
Median	9 visits	4 visits	9 months

Mental Health Addressed

Figure 7 displays the total number of visits by patient (blue) with the total number of visits where mental health was addressed (orange). Mental health was addressed at least once with all but one patient (patient #1) and was clearly a concern with most of the sample: 84% (41) had mental health addressed in at least 25% of their visits, 67% (33) in at least 50%, and 43% (21) in at least 75% of their visits. See Attachment C for more details.

Figure 7 | Total # of MSH Visits and # of Visits Addressing Mental Health, by Patient

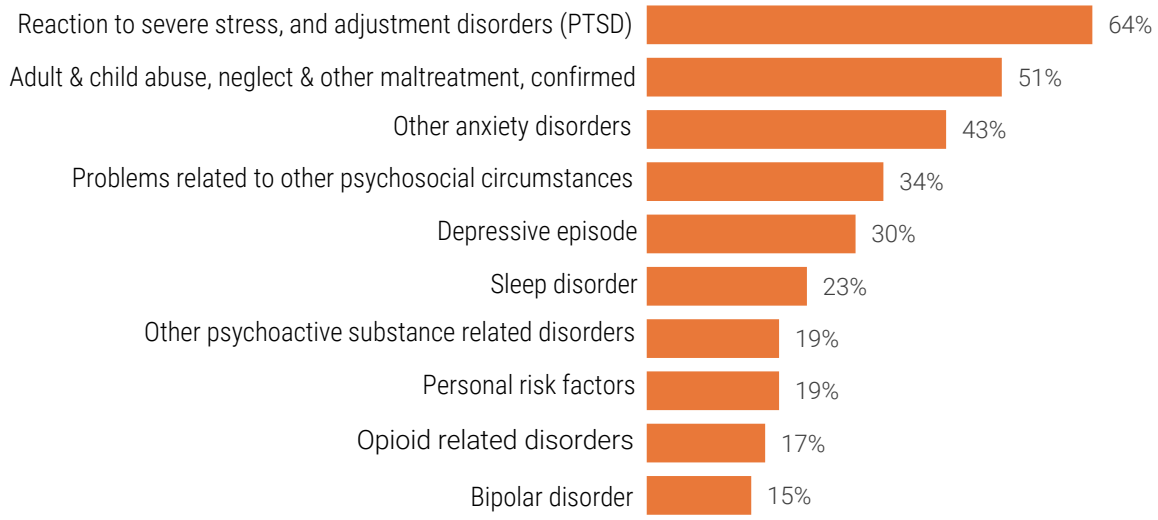


Of the retrospective sample, 36 patients (73%) received a prescription for medication(s) to address mental health, 11 (22%) did not receive a prescription, and two (4%) had no prescription information documented.

ICD-10 Diagnosis Codes

The records review included pulling mental health-related ICD-10 diagnostic codes to help understand the mental health status from the 49 retrospective clients. Of the 49 patients, 41 or 87% had at least one visit with a Mental, Behavioral and Neurodevelopmental Disorder code (an F code). **Figure 8** displays the ten ICD-10 codes based on the first 3 digits. The most reported code "Reaction to Severe Stress, and Adjustment Disorder" (PTSD) was reported in 64% of the patients at least once during their visits. See **Attachment D** for complete list of ICD-10 codes and counts of the number of patients per code.

Figure 8 | Top 10 ICD-10 Codes based on First 3 Digits of Code



Supplemental Mental Health Assessments

As noted earlier, the PCL-5 was the mental health assessment tool of choice for the prospective cohort. The PCL-5 is an assessment of trauma-related symptoms, which was the most prevalent cluster of mental health disorders for the MSH population. However, to more thoroughly evaluate the mental health of the retrospective cohort, two supplemental assessments were also measure in this group in the domains of depressive and anxious symptoms. These included the:

- PHQ-9, the Patient Health Questionnaire to assess degree of depression severity. Scores can range from 1-27, with score ranges indicating:
  - 1-4 minimal depression
  - 5-9 mild depression
  - 10-14 moderate depression
  - 15-19 moderately severe depression
  - 20-27 severe depression
- GAD-7, the Generalized Anxiety Disorder Assessment to assess the severity of anxiety. Scores can range from 0-21, with score ranges indicating:
  - 0-4 minimal anxiety
  - 5-9 mild anxiety
  - 10-14 moderate anxiety
  - 15-21 severe anxiety

The intention was to use the PHQ-9 and GAD-7 scores to measure changes in anxiety and depression for the retrospective cohort receiving MSH services. However, the small sample of assessments, 12 baseline PHQ-9s with 4 follow-ups, and 8 baseline GAD-7s with one follow-up, presented limitations to the findings.

Figure 9 displays the PHQ-9 scores for the 12 baseline and 4 follow-up assessments. Of the baseline scores, nine of the 12 scores indicated moderate to severe depression, and three of the four at follow-up showed an increase in depression severity. There is insufficient data to fully explain the overall trend towards increased depressive symptoms, however there are several plausible explanations. First, mental health disorders tend to follow a waxing and waning course, independent of treatment, based on a multitude of factors that cannot be well controlled for. It is also true that patients with dissociative subtype of PTSD may not be in touch with their depressive symptoms at the onset of treatment but get more in touch with their depressive symptoms as their PTSD is treated.

Figure 9 | PHQ-9 Baseline and Follow-up Scores

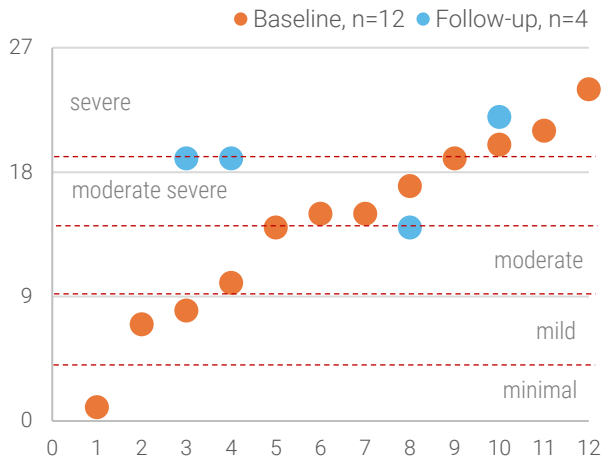
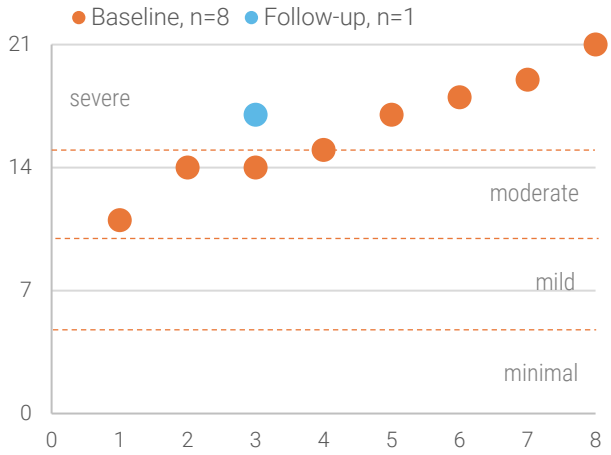


Figure 10 displays the GAD-7 scores for the eight baseline and one follow-up assessment. Of the baseline scores, all (100%) indicated moderate to severe anxiety at baseline, and the one patient with follow-up showed an increase in anxiety at follow-up. There is insufficient data to assess trends towards increased anxiety at follow-up, and ss mentioned in the above section, mental health disorders tend to follow a waxing and waning course, independent of treatment, based on a multitude of factors.

Figure 10 | GAD-7 Scores



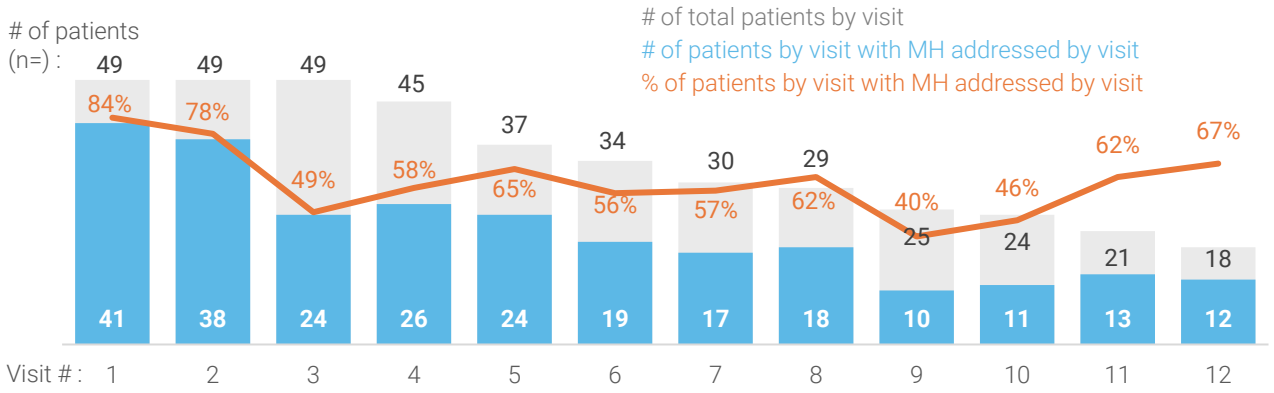
Medical Record Review

To help address the lack of quantitative data, a chart review was completed to document for each visit 1) if mental health was addressed, and 2) what the reported changes were in patients with a reported mental health status compared to the previous visit, reported in qualitative terms: Improved, Declined, No change, and None Reported.

Mental Health Addressed in Visit

Figure 11 displays the total number of patients seen for the first 12 visits, which was the average number of visits for this sample, and the number and percent of these patients whom mental health was addressed during the visit. The total number of patients decreased over time, from 49 patients at the first visit to 18 at the twelfth visit. In general, the percent of patients with their mental health addressed at each visit decreased over time as well, until the ninth visit (which was the median number of visits for the cohort) when the percent started increasing. Patients who had greater than nine encounters were more likely to have their mental health addressed during those visits.

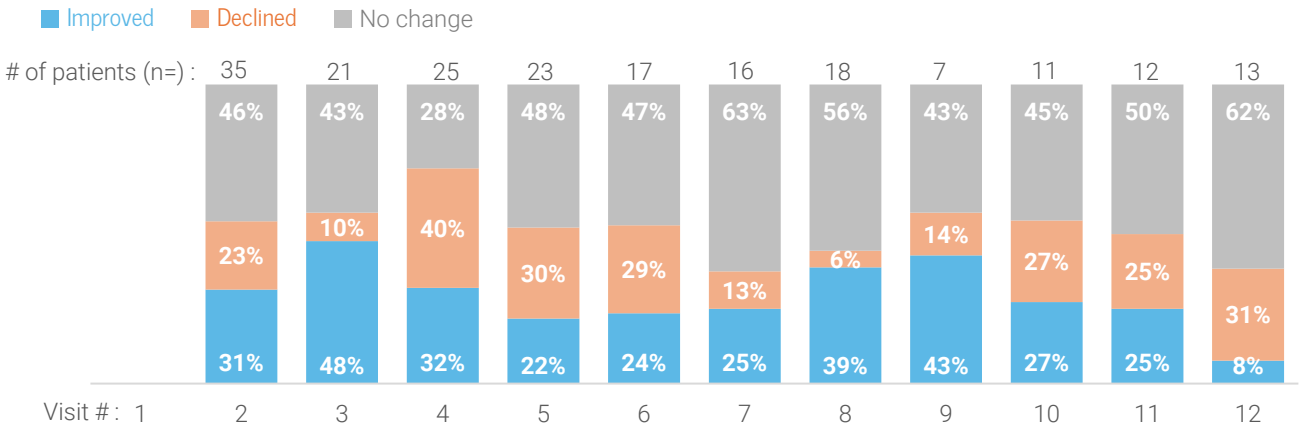
Figure 11 | Count and percent of visits where MH was addressed



Change in Mental Health

Figure 12 displays the reported change in mental health status during these visits, comparing each visit to the previous visit, for the first 12 visits (which was the average number of visits for this cohort). The first visit does not include any data since there is no previous visit to compare. The total number of patients varies per number of visits and is noted at the top of each bar. Patients with the mental health status listed as "none reported" were not included in the analysis. As the graph displays, and as previously noted with respect to fluctuating PHQ-9 and GAD-7 scores, mental health is fluid and changes throughout treatment, rather than following a linear path of improvement over the course of treatment.

Figure 12 | Mental Health Status Change in first 12 visits



MSH Resident Physicians and Staff

One of the focuses of the MSH program evaluation was to identify key elements in the MSH model to assist with expanding to other resident physician training programs. To assist with this, the evaluation included assessing MSH trainings, surveying 3rd year resident physicians at the completion of their residency, and interviewing staff from each site. This section of the report discusses these findings.

Each year, the number of new resident physicians to the family medicine clinics consisted of eight in Sacramento (except for 2018 when there were seven), eight in Northridge, and six in Redding. Resident physicians complete a three-year commitment. Sacramento is a well-established MSH site, with MSH resident trainings each year since 2016. Northridge began training resident physicians in September of 2020 and the first resident training in Redding was March 2021. Usually, MSH training is for first year resident physicians, but since the MSH model was new to Northridge and Redding, all resident physicians could participate. Therefore, the total number of resident physicians who participated in one or more trainings during the study period was 31 for Sacramento, 32 for Northridge, and 18 for Redding (see Table 6).

Table 6 | # of Resident Physicians per Site

	Sacramento	Northridge	Redding
2018	7	8	NA*
2019	8	8	6
2020	8	8	6
2021	8	8	6
Total	**31**	**32**	**18**

*Redding trainings did not include 2018 residents, since their trainings started in 2021

Trainings

Dignity Health provides training to all staff on human trafficking, but resident physicians in the MSH program are required to complete the MSH curriculum, which provides in-depth training to equip resident physicians with best practices to provide longitudinal care for victims and survivors of human trafficking. The trainings are also open to all faculty who provide MSH patient care. The three MSH trainings build upon each other, and include:

- **#1 Human Trafficking Medical Safe Haven** A physician perspective training on the scope, prevalence, and types of human trafficking which exist. The training discusses the impact on healthcare systems, and how the MSH model of care innovatively provides a non-judgmental compassionate care delivery model to assist victims and survivors of human trafficking.
- **#2 Trauma Informed Care** A training on the prevalence and impact of trauma and post-traumatic stress disorder (PTSD), signs and symptoms of trauma and PTSD, and considerations on the impact of trauma experienced by staff, patients, and communities. Understanding the intersections of trauma guides MSH staff and physicians who provide in person care and services to victims and survivors and teaches the guiding principles of the trauma informed approach to health care.
- **#3 Patient Physician Encounters** This final MSH training helps resident physicians build the logistical skills needed for a survivor centered approach to care and provides clinical recommendations for the patient encounter. This training helps resident physicians recognize physical indicators of trauma, how to engage patients and build trust while validating their trauma experiences, and to learn about potential triggers when working with patients to reduce re-traumatization. The training also discusses clinical best practices on laboratory evaluations, adjunct medication treatments for physical ailments and

complex PTSD, proper documentation and coding, arrangement of interagency collaboration, and how to recognize and avoid vicarious trauma.

Most of these trainings were in-person trainings, but during the COVID-19 pandemic related stay-at-home order, some trainings were provided via Zoom.

At the end of each of the MSH trainings, resident physicians completed anonymous subject-specific training surveys (either a paper survey or a link to a web-based survey). The survey design was a post-survey with retrospective pre-survey and included subject specific questions on awareness and confidence when working with trafficked victims and survivors. The retrospective pre-survey questions asked trainees to *think back prior to the training* and select that best response for **before** attending the training. The post-survey questions asked participants to select a response for **now**, after participating in the training. The questions were different for each training.

The surveys also included questions to assess training satisfaction, and these questions were the same for the three surveys. This surveys also provided the opportunity for narrative feedback with an open-ended question: *what additional information do you need to help you as a physician working with human trafficked victims/survivors?*

All survey questions used a 5-point Likert scale, with the definition of the scale varying per section of the survey. Survey completion was voluntary, and training participants could opt out at any time including not answering questions after starting the survey. When web-based trainings were conducted during the stay-at-home order, the survey response rate for online surveys was lower than that of the paper surveys administered during in-person trainings.

The following section displays a summary of findings for each of the subject specific surveys by training:

- MSH Training #1 | Human Trafficking Medical Safe Haven Training
- MSH Training #2 | Trauma Informed Care Training
- MSH Training #3 | Patient Physician Encounters Training

These training summaries are followed by a section that shared findings on training satisfaction and includes a thematic analysis of responses to the question: *what additional information do you need to help you as a physician working with human trafficked victims/survivors?*

MSH Training #1 | Human Trafficking Medical Safe Haven Training

In total, 75 Dignity resident physicians and staff attended the Human Trafficking Medical Safe Haven Training (HTMSH), and of these 47 responded to the training survey, a 63% response rate. Most respondents were resident physicians (85%) in their first year (49%), with the largest representation from Northridge (55%) (Table 7).

Table 7 | Description of Human Trafficking MSH Survey Respondents, n=47

Location	# respondents	%
Northridge	26	55%
Redding	9	19%
Sacramento	12	26%

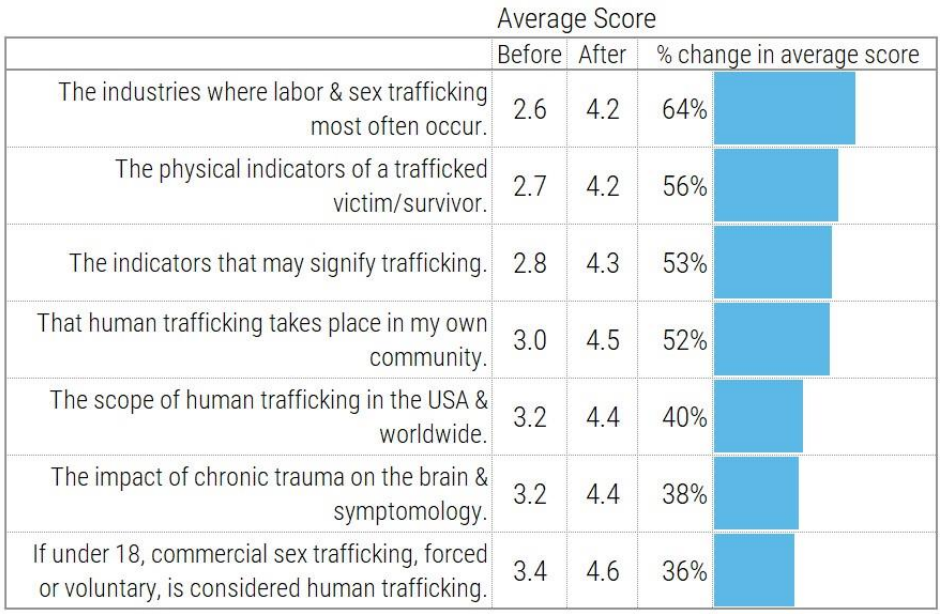
Position	# respondents	%
Resident physician	40	85%
Other (medical student, staff, etc.)	5	11%
Missing	2	4%

Resident Year	# respondents	%
PGY-1	23	49%
PGY-2	6	13%
PGY-3	8	17%
Missing	10	21%

The HTMSH Survey measured changes in human trafficking awareness, knowledge, and confidence using a 5-point Likert scale, with respondents selecting answers representing "before" and "after" training. Figure 13 displays average scores for each statement and the percent increase after the training.

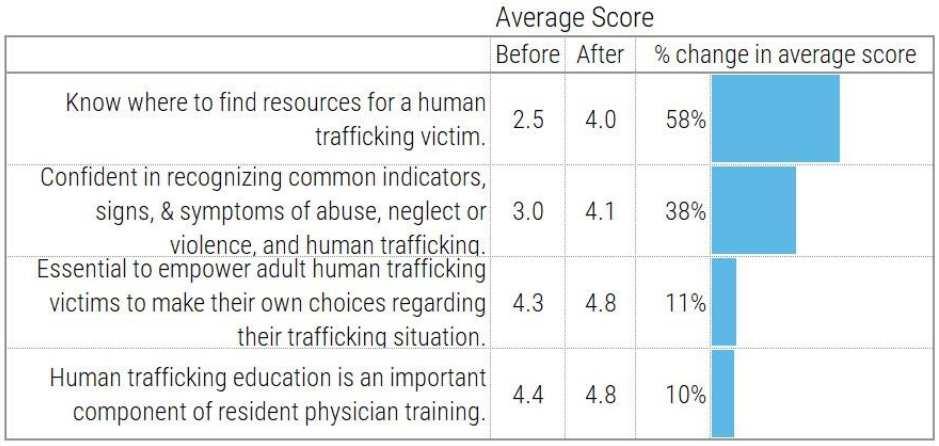
Figure 13 | Human Trafficking Medical Safe Haven Training Survey Results

Human trafficking awareness scores increased 36% to 64%.



The 5-point Likert scale range: 1=not at all aware to 5=extremely aware.

Human trafficking knowledge & confidence scores increased 10% to 58%.



The 5-point Likert scale range: 1= strongly disagree to 5=strongly agree.

It is important to note many of the scores were high to begin with, inversely affecting the percent increase. For example, resident physicians reporting human trafficking education as an important component of resident physician training was 4.4 prior to the training, increasing to 4.8 after, a 10% increase.

MSH Training #2 | Trauma Informed Care Training

In total, 88 Dignity resident physicians and staff attended the **Trauma Informed Care Training** (TIC), and of these 55 responded to a training survey, a 63% response rate. Most respondents were resident physicians (84%) in their first year (49%), with the largest representation coming from Sacramento (40%) (see Table 8).

Table 8 | Description of Trauma Informed Care Survey Respondents, n=55

Location	# respondents	%
Northridge	19	35%
Redding	14	25%
Sacramento	22	40%

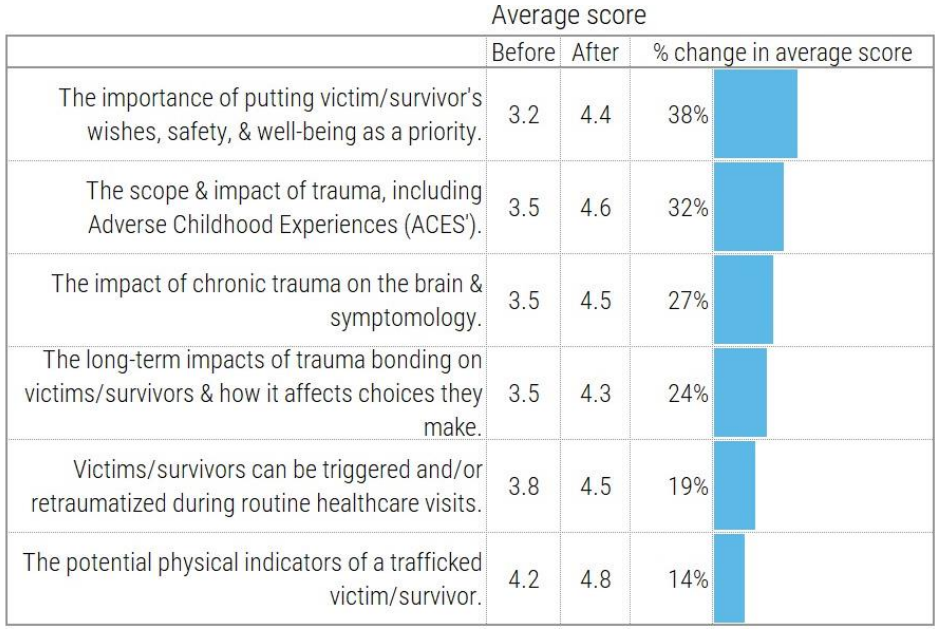
Position	# respondents	%
Resident	46	84%
Other (medical student, staff, etc.)	8	15%
Missing	1	2%

Resident Year	# respondents	%
PGY-1	27	49%
PGY-2	8	15%
PGY-3	8	15%
Missing	12	22%

The TIC Training Survey measured changes in the awareness of trauma in health and healthcare and trauma informed care knowledge and confidence, using a 5-point Likert scale, with respondents selecting answers representing "before" and "after" training. Figure 13 displays average scores for each statement and the percent increase after the training.

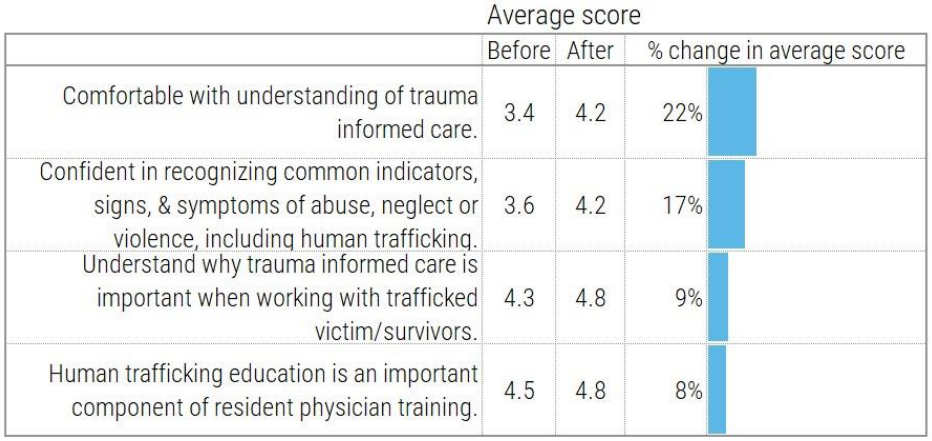
Figure 14 | Trauma Informed Care Training Survey Results, n=55

Trauma awareness in healthcare scores increased 14% to 38%



The 5-point Likert scale range: 1=not at all aware to 5=extremely aware.

TIC knowledge & confidence scores increased 8% to 22%



The 5-point Likert scale range: 1= strongly disagree to 5=strongly agree.

It is important to note many of the scores were high to begin with, inversely affecting the percent increase. For example, resident physicians reporting human trafficking education as an important component of resident physician training was 4.5 prior to the training, increasing to 4.8 after, an 8% increase.

MSH Training #3 | Patient Physician Encounters Training

In total, 58 Dignity resident physicians and staff attended the **Patient Physician Encounter Training** (PPE), and of these 45 responded to the training survey, a 78% response rate. Most respondents were resident physicians (91%) in their third year (33%), with the largest representation coming from Northridge (69%) (see Table 9).

Table 9 | Description of Patient Physician Encounters Training Survey Respondents, n=45

Location	# respondents	%
Northridge	31	69%
Redding	4	9%
Sacramento	10	22%

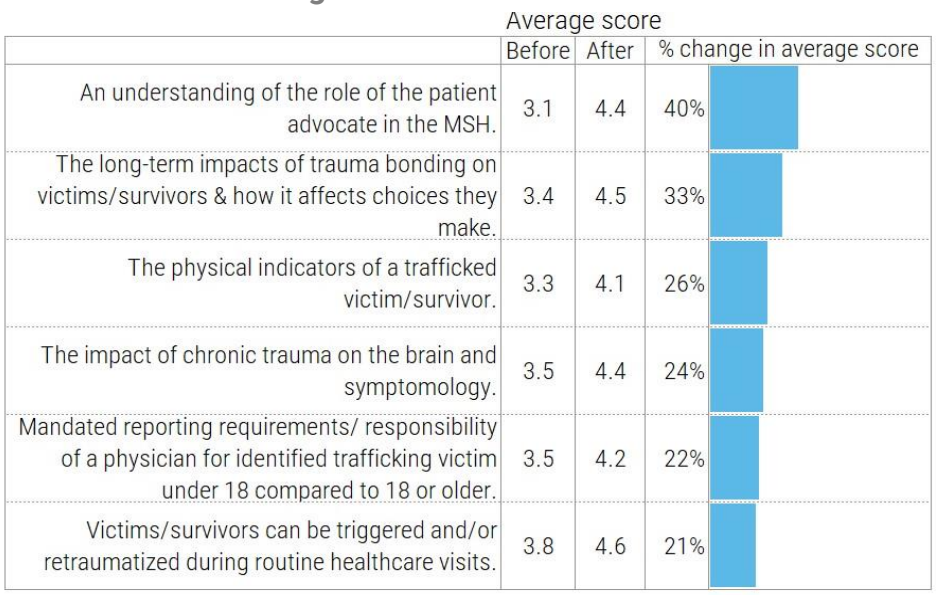
Position	# respondents	%
Resident	41	91%
Other (medical student, staff, etc.)	3	7%
Missing	1	2%

Resident Year	# respondents	%
PGY-1	12	27%
PGY-2	12	27%
PGY-3	15	33%
Missing	6	13%

The PPE Training is the final of the three main MSH trainings and summarizes how to use the information learned and discusses clinical practices. The PPE Training Survey measured awareness, knowledge and confidence of working with trafficked patients, using a 5-point Likert scale, with respondents selecting answers representing "before" and "after" training. Figure 15 displays average scores for each statement and the percent increase after the training.

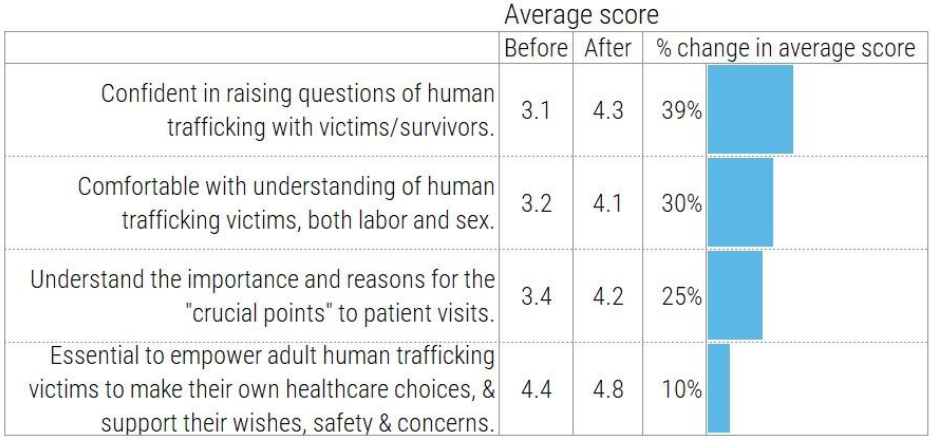
Figure 15 | Patient Physician Encounters Training Survey Results, n=45

Trauma and trafficking awareness scores increased 21% to 40%.



The 5-point Likert scale range: 1=not at all aware to 5=extremely aware.

PPE Knowledge and confidence scores increased from 10% to 39%



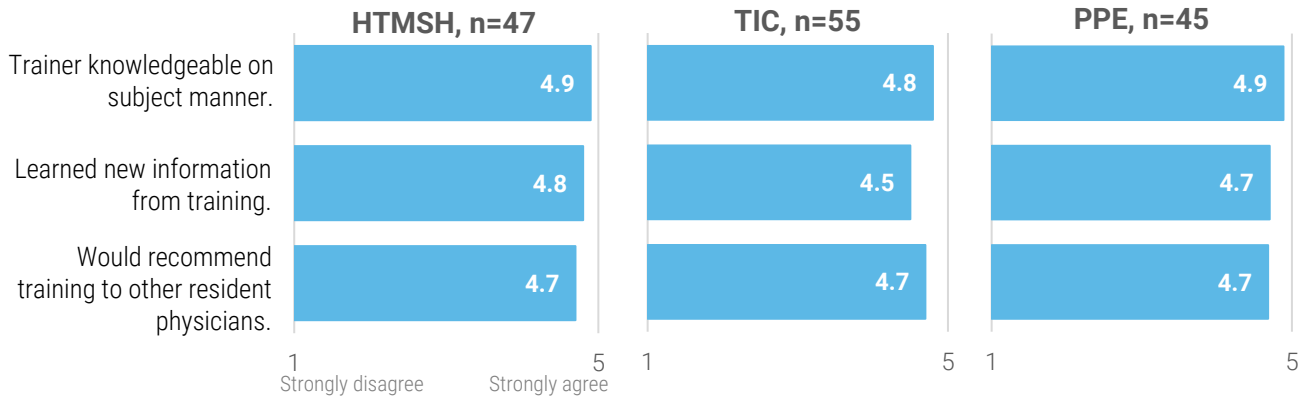
The 5-point Likert scale range: 1= strongly disagree to 5=strongly agree.

It is important to note many of the scores were high to begin with, inversely affecting the percent increase. For example, resident physicians reporting it is essential to empower victims was 4.4 prior to the training, increasing to 4.8 after, a 10% increase.

Training Satisfaction and Recommendations

All three MSH training surveys ended with same satisfaction statements, using a 5-point Likert scale to rate three statements on the training (1=strongly disagree and 5=strongly agree). The average scores were from 4.7 to 4.9 for the HTMSH training, 4.5 to 4.8 for the TIC training, and 4.7 to 4.9 for the PPE training (See **Figure 16**).

Figure 16 | Satisfaction Questions by Training, Average Score



Lastly, each training survey concluded by asking if there was any additional information needed to help resident physicians work with human trafficked victims/survivors. Responses were few (13 or 28% from MSH trainings, 11 or 20% from TIC trainings, and 8 or 18% from PPE trainings). A content analysis of the responses identified three main themes that carried through among all three surveys: resources, experience, and additional training.

Resources Repeatedly, training participants requested information on resources, such as an "easily accessible resource sheet" or a list of "established network of trauma informed providers" and information on legal resources available to the MSH and how "the clinic can help folks get into social safety net programs (e.g., food stamps, housing) to have stability they need to get out of exploitive situations." Another suggested resource was a list of questions to help facilitate a conversation with trafficked patients and encourage them to open up about their experiences.

Experience Many resident physicians stated they just need more experience with trafficked patients, as well experience with the MSH tools and processes. Suggestions to help prepare them for this experience included someone to consult with, such as an experienced staff person and role-playing as practice. It was also suggested resident physicians come speak about common challenges they face in the MSH clinic and share stories of how traumatized patients present as ways to help prepare them for recognizing trafficked patients

> "I feel like I have been well-trained from this session and previous sessions and the main way to increase my understanding is to have more experiential learning."
>
> - Sacramento Resident Physician

Trainings Ongoing trainings as well as using case examples and hands on experience, such as in the PPE training format were suggested. Suggested trainings included:

- Questions to ask patients during encounters.
- Developing skills around utilizing trauma informed care.
- Trafficking recognition to help identify victims/survivors who do not self-identify, such as branding tattoos used.

> Hands on experience to put today's training into practice, so that I can have real experience in case I would like to continue post-secondary training.
>
> - Northridge Resident Physician

3rd Year Resident Physicians

MSH resident physicians in Sacramento completed a MSH 3rd Year Resident Survey at the conclusion of the third year of their residency. The purpose of the survey was to gather information on acquired skills and confidence when working with victims/survivors; see how resident physicians used what they learned; and hear how they anticipated using trauma informed care and victim-centered approach to care in the future. The survey did not include any identifying information, survey completion was voluntary, and resident physicians could opt out at any time including not answering questions after starting the survey.

The original evaluation plan was to retrospectively include 3rd year resident physicians from the Sacramento classes of 2018 and 2019 by emailing a survey link. As **Table 10** shares, the completion rate was low (2 out of 7 resident physicians for 2018, and 1 out of 8 for 2019). In 2020, Northridge and Redding were added to the evaluation with the plan to have 3rd year resident physicians in each site complete a paper survey at one of their standing meetings, to assure a high completion rate. However, due to the COVID-19 pandemic, 2020 3rd year resident physicians also completed the survey on-line and 2021 3rd resident physicians used a combination of both on-line and paper surveys. **Table 10** displays the number of 3rd year Resident Surveys completed by site and class. Most of the surveys are from Sacramento (17 of the 30) because: 1) Sacramento included four classes of resident physicians, and 2) the overall response rate was higher (55%).

Table 10 | 3rd Year Resident Survey Completion by Site and Year, n=30

	Northridge		Redding		Sacramento	
	# of surveys	Response rate	# of surveys	Response rate	# of surveys	Response rate
2018	-	-	-	-	2	29%
2019	-	-	-	-	1	13%
2020	5	63%	1	17%	8	100%
2021	2	25%	5	83%	6	75%
Total	**7**	**22%**	**6**	**33%**	**17**	**55%**

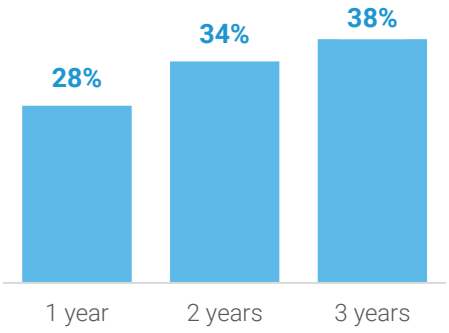
There were a few issues that affected the 3rd Year Resident Survey response rate:

1. Collecting a survey retrospectively when resident physicians moved on from Dignity Health and have embarked on their careers.
2. Web-based surveys are often missed, can be removed by SPAM filters, and/or people plan to respond later and forget.
3. In 2021, Northridge and Redding 3rd year resident physicians received the survey later than intended, and many were wrapping up their residency and did not complete the survey.

The evaluation team discussed timing and, if collected in the future, would recommend a paper survey administered during a regular meeting mid-year of the third year as to not compete with other obligations that 3rd year resident physicians face at the end of their residency.

The survey collected information about resident physicians' experience working with trafficked victims/survivors by asking how many years they worked in the MSH and how many trafficked patients they treated. Table 11 displays the number of years working in the MSH. A little over one-quarter (28%) reported working with trafficked victims/survivors for one-year, and 34% reported two years. Since the three MSH sites started at various times and new resident physicians begin every year, some of the resident physicians had one to two years of experience before completing their residency (28% and 34% respectively) compared to those that had three solid years working in the MSH (38%), such as Sacramento 3rd year resident physicians from the classes of 2020 and 2021.

Table 11 | # years working with trafficked victims/survivors, n=29



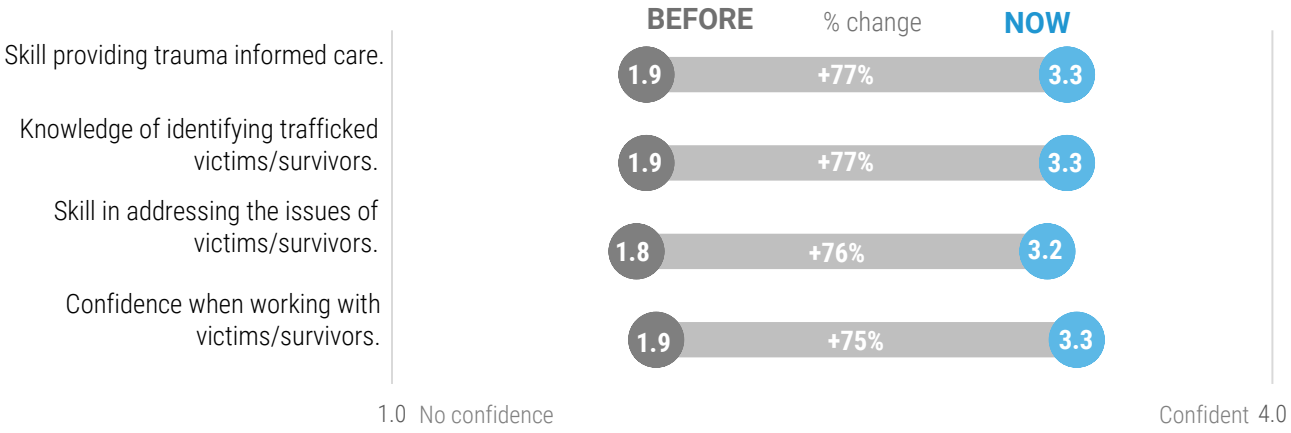
The number of trafficked victims/survivors that resident physicians worked with previously ranged from 0-40, with a mean of 12.6 patients per resident.

Quantitative Survey Findings

The first section of the survey asked resident physicians to rate their confidence for four statements, comparing when they first started working in the MSH to "now" after working in the MSH, using a 4-point Likert scale (1=no confidence and 4=confident). Not surprisingly, resident physicians' self-reported confidence was higher "now," with the greatest increases being for the statements, "How would you rate your skill providing trauma informed care," and "How would you rate your knowledge of identifying trafficked victims/survivors." With both statements, confidence scores increased from 1.9 before working in the MSH to 3.3 now, after working in the MSH, representing a 77% increase (see Figure 17).

By the third year of residency, there was a 75%+ increase in knowledge and confidence scores regarding working with trafficked victim/survivors.

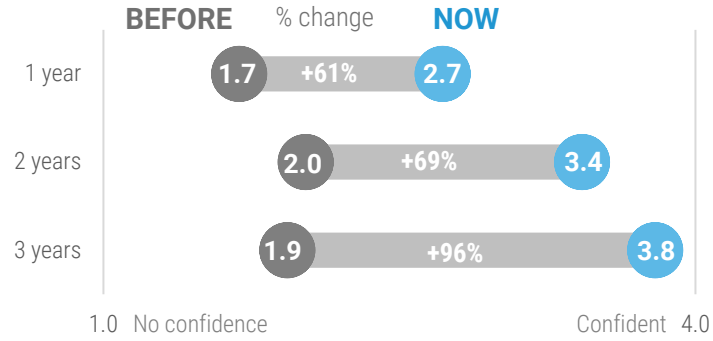
Figure 17 | 3rd Year Resident Survey, n=30



The longer the resident physicians worked in the MSH, the more their knowledge and confidence scores increased.

Increases in skill, knowledge, and confidence increased with the years of experience resident physicians had working in the MSH. There was a 96% increase in confidence scores among resident physicians who were with the MSH for all three years, from 1.9 to 3.8, compared to those working in the MSH one and two years, a 61% and 69% increase respectively (see Figure 18).

Figure 18 | Average change by # years working in the MSH, n=29



Qualitative Survey Findings

The survey concluded with open-ended questions to learn more about how MSH experiences prepared resident physicians for working with trafficked victims and survivors and how they plan to use these experiences. A content analysis of responses identified themes and findings include the following.

How experience(s) at the MSH prepared resident physicians to care for the medical needs of trafficked victims and survivors using a victim centered approach.

Of the 30 resident physicians who participated, 23 (77%) provided a response. Two of the resident physicians reported they had not started working with trafficked victims/survivors, so they were unable to provide input. The analysis of the remaining 21 resident physicians' feedback identified the following themes.

Communicating with Victims and Survivors Through trainings and hands-on experience with victims/survivors, many resident physicians reported that they learned how to talk to and communicate with this population, such as how to initiate the conversation and/or what questions to ask to open the dialogue. They also learned to listen and how to make victims/survivors feel comfortable sharing their stories, and to accept "whatever the person is sharing in a non-judgmental way."

Comprehensive Training The comprehensive training program helped to "open my mind" and as one resident stated: "It has made the most impact on my medical career." The trainings on what "human trafficking actually is and how prevalent it is in our community was the most eye opening" as well as what nonverbal concerning clues to look for during clinic encounters. Learning about trauma informed care and how to talk with victims/survivors was crucial to their work and taught them how to "make the victim and survivor feel more confident in their provider."

> "Gave me a framework to think about [how victims/survivors feel during] encounters with medical professionals (especially from the perspective of a chronically traumatized patient). Allowed me to loosen the structure for interview, understanding that there was no way to "get" the patient to tell me a straight story and that trying to do so wasn't helpful for either of us. Gave me permission to not always get "all the data" if it came at the expense of making a patient feel like they weren't in control of the encounter and if they didn't feel safe because of it."
>
> - Sacramento Resident

Trauma Informed Care The awareness of trauma informed care as well as signs of human trafficking is key to successfully providing care to trafficked victims/survivors. Through the MSH experience, resident physicians learned the unique challenges faced by victimized patients and techniques that are helpful and applicable to the unique situation(s) of each patient. These experiences provided them with tools needed to treat this vulnerable population.

Importance of Shared Decision Making It is important to share decision making when working with this population to help empower victims and survivors. One resident mentioned that hearing the experiences of victims and how "we as providers can support them" is what helped the most.

Patient Advocates The role of the Advocate was mentioned as one of the key elements to the program. Talking with the Patient Advocate helped resident physicians learn about providing patient-centered trauma informed care and having the Patient Advocate available to provide supports to the patient during the visits was crucial.

Extra Time with Patients Time was also mentioned as key to providing this care. The importance of the clinic structure to give the physician time, not to just talk with and care for the patient, but for mentorship as well.

Additional trainings and/or experiences to help resident physicians when working with trafficking victims/survivors.

Of the 30 resident physicians completing the survey, 25 (83%) responded to the question asking what additional trainings and/or experience they needed to help them work with trafficking victims/survivors. Five resident physicians felt they did not need any additional training and/or experience. Of the remaining, most reported they just needed more "hands on" or "real life" experience. Other suggested trainings included:

- Working with trans patients
- Training on resiliency
- Learning more about community resources
- Training on legal issues victims/survivors face
- Annual refresher trainings.

Lastly, one resident suggested videos of practice encounters to help them prepare.

Plans for utilizing what they learned in the future.

The survey concluded with asking resident physicians how they plan to utilize their experiences with the Medical Safe Haven in the future. Of the 30 resident physicians who completed the survey, 24 (80%) resident physicians shared their plans.

All respondents said they plan to continue using the skills they learned in future care, such as using screening questions, noticing "red flags", or recognizing signs and "subtle little cues" of trauma and trafficking, "starting the conversation" with patients, and knowing community resources available to trafficked victims and survivors. Some respondents were more specific about their plans, which included:

Trauma Informed Care Resident physicians planned to continue using the trauma informed approach to care and take this into their everyday practice, realizing that this approach works for all patients, not just those with identified as trafficked victims/survivors.

Patient-Centered Approach to Care Continuing a patient-centered approach to guide the care they provide, as one resident stated, "…we can be very effective as physicians in providing a safe place for these victims to obtain care."

Initiating Future Trainings In addition, some resident physicians planned to initiate trainings on trauma informed, patient-centered care in their future clinic, as well as learn about and develop relationships with community resources.

Continuing the Medical Safe Haven Work Lastly, many resident physicians reported they would like to continue to work with this population, with a couple even mentioning that they planned to create their own MSH clinic.

> Trauma informed care is now a regular part of my practice, regardless of whether I'm working with trafficking victims/survivors or not. I pay attention to non-verbal communication more critically and inquire about those kinds of things on a regular basis to figure out if it is just an "odd behavior" or more of a red flag. If I'm ever in a practice setting where trauma informed care is not practiced, I'd advocate for training for all staff (not just physicians).
>
> - Sacramento Resident

> These experiences have been instrumental in developing my approach to patient care. I plan to start a Medical Safe Haven in my future practice and to teach the other physicians to care for these patients there. I discussed this with them prior to joining.
>
> - Sacramento Resident

MSH Staff Interviews

To help gain a deeper understanding about physician and staff experiences in the MSH, the evaluation included semi-structured interviews with MSH staff (3 physicians, 5 resident physicians, and 1 nurse) from the three MSH clinic locations (4 from Sacramento, 3 from Northridge, and 2 from Redding). Staff experiences working with MSH victims/survivors varied, from working with a total of two to 40 MSH patients.

The interview protocol consisted of 14 questions to learn the strengths and challenges of the MSH model and the impact of trainings and MSH experience on professional development. These interviews took place via Zoom during the summer of 2021.

Motivation for Joining MSH

Some staff shared their motivation for working with the MSH, which ranged from lived personal experience to the calling to work with underserved populations.

> When I was 16, someone followed me to my physical therapist and almost kidnapped me. When I reported it, the police said there was two men kidnapping young girls... If I have the opportunity to talk to these women who were kidnapped and forced into trafficking, hopefully I can guide them. So that was my opportunity to get involved.

> I'm from the Central Valley so labor trafficking has always been on my mind, wanting to know people are safe and knowing people aren't identified or get services because of barriers, like language, physical barriers, financial barriers, not having means to afford services, having difficulty asking for help or having someone stopping them from getting help. So, I was excited to work with this patient population.

General Perceptions

In general, initial staff perceptions included excitement about working at the MSH, but also anxiety about the unknowns about serving this patient population. However, these initial anxieties were resolved as they gained experience, training, and built rapport with patients.

> [I was] stressed out because I wasn't sure what to expect with my responsibilities as a doctor. So, that caused a little anxiety, a world of known stuff and I didn't know what to expect; but the whole idea of it I thought it was really positive and wanted to be involved… but the anxiety is reduced now and almost gone.

All interviewees spoke highly of the clinic, the model of care, and their experiences with the clinic.

> It's been very positive in my professional life and personal life; the pandemic has made this year hard, and this was a very positive thing to come out of it. It's also heartbreaking, but it is positive that we can offer care to patients that are so damaged, but also invigorating

Strengths of MSH

The Model of Care

The interviewees responded to questions about the MSH and how the clinic is different or helped their work with trafficking victims and survivors. Responses identified several strengths that are key components to the MSH model of care, which are summarized below.

> Meeting instability with flexibility, which doesn't fit the [traditional] medical model.
> - Sacramento Staff

Procedures for Trafficking and Trauma Clinic staff received several trainings to learn about working with trafficking victim/survivors to help raise awareness about the many unique circumstances victims/survivors face. Due to the challenges of working with this population, sites have policies and procedures specific to trafficking victim/survivors to help ensure their safety and the safety of the clinic staff. One such policy is for patients to attend the initial visit without a partner or friend. The Advocate attends the visit with the patient.

> We have a "see alone" policy initially, and then [subsequent visits] will take whoever is with them back. If there is a support person there with them, we acknowledge the person is there, and [try to] determine if they really are a support person [as opposed to an abuser]. If there is an issue, [such as an abuser with them] how do we ensure the safety of everyone in the clinic? Because police are not always the safest option. So having [a policy and all the staff] on the same page and aware of that.

Staff knowledge of trafficking and trauma helps doctors come up with realistic health goals for their patients and helps them be mindful to not assume certain aspects of their patients' lives.

> Their daily life is not anything like a normal person. To a lot of patients I say, "go home, go to the lab when you have time." For some [MSH] patients it's not that simple: leaving and going home can be dangerous, being at home can be dangerous. So, I have to rethink everything I tell my patients. Sometimes I tell patients to walk outside for 30 minutes a day. Depending on who is keeping tabs on them, that might not be realistic thing, that could actually be threatening their life.

Time A key difference between a doctor's visit at a typical clinic compared to an MSH clinic is the length of time for visits. One interviewee noted that the first visit at an MSH clinic is generally 90 minutes, and subsequent visits are 45 minutes to one hour. Several interviewees cited visit length as an important factor in the success of the MSH model, allowing them to not be as rushed with patients and to better accommodate when patients are late to appointments. One resident, however, commented that although MSH appointments theoretically have more time allocated with the patients, that was not their experience.

Whole Person Care Several doctors spoke on the importance of whole person care in serving victim/survivors of trafficking.

> I think the multi-disciplinary team is so crucial; the providers can't do it on their own, no one can; we need to work together to ensure that we provide resources to help our MSH patients.

Part of the multi-disciplinary team includes the Patient Advocate and community partners.

Patient Advocate All interviewees shared that the Patient Advocate is an important element of the whole person care model in the MSH. The doctors interviewed had no shortage of positive things to say about the Patient Advocate on staff at their MSH clinics and the importance of this role. As one physician stated, "she is the thing; she's the continuity, the glue; she navigates [the systems]." All cited Patient Advocates as key to the success of MSH. Doctors commented on the Patient Advocates' relationships with patients, connections to resources in the community, and overall helpfulness in the clinic.

> [The Patient Advocate] is incredibly helpful. It's the fact that she sits in on every patient visit and hears everything that is said and she's able to give background information. She's very connected to everyone who interacts with patients and knows what the patient does outside the clinic. She gives me a comprehensive view of what this person's lifestyle is like. She also knows everything I need to get done for patients and she arranges everything. And if the patient is Spanish speaking, she's especially helpful [because she speaks Spanish].

> Our Advocate is amazing. She allows the patient to express themselves, gives us a heads up about issues that may be difficult, and gives us feedback. For instance, one time I untied something [in front of a patient] and that was triggering for the patient. [The Patient Advocate] told me later and I was able to apologize to the patient. She has been a quiet, effective leader in helping patients feel safe. We couldn't do it without her.

> We couldn't do this without the Advocate; coordination, trust, follow-up, the 2-minute skinny before I see the patient, I can walk in knowing something about the patient; having that… the reason they can give that to me is because they're working with them, coordinating with partners. It saves me time and I can go in and have a much more informed, trust building encounter with them. I'm not interrogating, looking like I have no idea what's going on; it shows that I'm part of the team they've already been working with

Community Partnerships Several doctors identified community partnerships as a key aspect to the success of whole person care, and by extension, the Medical Safe Haven model. Partnering with the community at an agency level and interpersonal level creates an environment for patients and physicians to build trust more easily as part of an ecosystem of support.

> A lot of work has been done so that physicians and staff know the faces of community partners outside of just a patient encounter. We have meetings [with community partners] where we're introducing what's working, what's not working. So, when a community partner brings a client in, we know the partner, and the partner knows us, and there is the ability [for the community partner] to talk to a patient/client ahead of time and say they know these people, this is how they will help you, and you can trust them. So, the community partnership is not just company to company, but the interpersonal human connection is there, and that's critical.

Support from leadership Two interviewees commented that for MSH to succeed, there needs to be buy-in from leadership and senior management to ensure that it is a priority.

> High levels of senior management support are important… if it's not on senior management level radar, things don't work, they don't happen. So, keep it in the purview of senior management. If there's things your clinic needs, not just money, but support from all across the division, you need to have one or two senior managers that see it as a priority, otherwise it gets pushed to the wayside.

Relationships with Patients

One factor to maintaining long-term health care connections is strong healthcare provider-to-patient relationships. Interviewees spoke to this when discussing the MSH model of care.

Listening to Patients Several interviewees commented on the importance of listening to patients as partners on the healthcare journey, especially when serving trafficking victims and survivors.

> Giving them the control about what's going to happen—giving them control and choice about their healthcare. The first visit can be very intense… so, doing what you can to be supportive.

> I think honestly just listening, not butting into the conversation, and also not telling the patients what to do. It's more about creating a plan together, determining what is reasonable. At the end [of a visit] I like to reiterate that [the medication or treatment] may not work the first time, but I want them to know I'm there and the whole team is there for them. If one thing doesn't work, we can always try something else.

Consistency of Care Several interviewees spoke on the importance of consistency in trafficking victim/survivors and how consistency through MSH can help develop trust with patients.

> Consistency, not just in the clinic but among all business partners in the community [is important]. One thing that our victims don't have is consistency. They lack trust because they don't feel that they'll be able to depend on people, so we can develop that trust with those human trafficking victims with consistency.

Challenges with the MSH

Patient Needs

Interviewees noted several challenges working with trafficked victims/survivors. These challenges are discussed below.

Trauma One of the challenges of serving patients at the MSH is the nature of the lives of victim/survivors of trafficking; patients often suffered extreme trauma and have acute mental health and substance use challenges. This can make it difficult for patients to interact with the healthcare system.

> We're available 8 to 5 and their lives go on. Often there is substance use disorder, and their lives are very chaotic. So, the nature of chaos, trying to interact with a pretty rigid [healthcare] system. We have to be really flexible. If they show up, you see them, which can be disruptive to your life and schedule. And, having been trafficked, their needs can be really overwhelming, and you have to do what you can do.

> They often have acute mental health issues, and they don't fit great into the mental health system… I have a trafficked patient and she doesn't like men, but all the emergency department doctors are men, so she has to interact with this man, and it's traumatizing for her to interact with men.

Addressing Long-term Health Since many patients have not received recent healthcare prior to visiting MSH, there can be immediate healthcare concerns that often take precedence over longer-term health care goals, making it harder to address these longer-term goals.

> Often the immediate health concerns are what is first addressed at intake appointments, in addition to trying to learn more about them, so it can be challenging to get them to come back to focus on long term health. Often times they are as overwhelmed as we are about where to begin to ensure they have a healthy lifestyle and taking back control of their body autonomy and health.

Transportation Most interviewees commented on transportation being a significant barrier to care for MSH patients, especially considering the safety concerns that can be present for victim/survivors of trafficking. While clinics do have some funding for transportation, ongoing funding is difficult to secure.

> Transportation is huge and getting funding for that is huge. Funding was lost for a while, and it really affected things. We had one patient show up with her kids in an Uber without car seats.

Child Care Another challenge that was mentioned was when patients show up for an appointment with their children, and they don't have privacy with the patient, or the place or staff to watch the children.

> We stocked toys and games for kids. One challenge is that patients bring their children to the appointments. We don't ask them to disclose things we think the kids shouldn't be hearing, but sometimes they do. And we don't have someone to watch the kids. We don't want them listening to certain things.

MSH Structure

Interview participants also discussed some of the challenges with the MSH structure.

Funding Several interviewees spoke about the funding or financial barriers than can present difficulties for accessing care for MSH patients.

> If I want to order certain studies, funding can be an issue. One patient had hyperthyroidism, and I ordered many expensive studies for her workup, and she was still getting signed up for MediCal. I needed to treat her soon, because her heart was going to explode. Fortunately, our coordinator used a grant [we had] and we got the studies covered.

Funding can become even more of an issue when the patients no longer receive healthcare funding through MSH and are expected to pay for healthcare on their own.

> There are also financial barriers, like getting them the right meds can be challenging. Our grant money does let us do some medication for a timeframe, so they are subsidized and free to the patient. The pharmacy we go to charges to the grant account, but after a certain point the patient has to take over and they have to be able to afford meds, which is difficult if they don't have a job yet.

Along with funding restraints, there are logistical challenges with billing the current funding.

> Our problems have been with making sure we get labs paid for and sent to lab correctly since it is outside of our normal model, since we have to make sure it's billed to MSH… The patients are heart wrenching, but it's the logistics that can be difficult.

Mental Health and Specialty Care Several interviewees spoke to the challenges in accessing specialty care and consistent mental health support.

> There's such a lack of people trained to do [mental health] work and it's difficult to see patients struggling to get a therapist long term. Typically, they have them for a couple years, then the therapist might leave, or funding might be over and it's hard to not feel abandoned. So more stable providers would help.

> It would be great to have a really easily available mental health, a therapist that I could hook them up with very easily; someone who has experience in substance use and therapy, who was available a lot, because right now I have to get in line with the other clients. It would be great to have a mental health professional, someone who could de-escalate, help with substance use.

Accessing specialty care presents similar issues, and interviewees spoke to the importance of having community connections to support patients with specialty care needs.

> We had a diabetic patient who had been labor trafficked… and she had been unable to access medical care for many years. She went blind in one eye on Saturday night. I convinced a local ophthalmologist to see her for free. That's a challenge. He'll see her next week but getting specialty care has been an issue. Certain aspects of healthcare are very expensive. And we do the basics well, but some patients have things like facial trauma. There's a group that does facial reconstruction, and [our Patient Advocate] helps patients get connected with that. [Our Patient Advocate] is always looking for other specialists that can support.

Changing Resident Physicians While the MSH clinic living within the residency program presents excellent learning opportunities for new physicians, one interviewee wondered if patients feel abandoned when they lack continuity with the same doctor.

> A big challenge is getting continuity – I love having residency clinics, especially in family medicine, but sometimes when someone comes in for the check-up it's not always the same person [doctor]…I don't know if they feel abandoned, but parts of me feel like I'm abandoning the patient.

Data System One staff commented on the lack of a patient management system within the electronic health record for use with MSH patients, and that using an Excel Spreadsheet to track patients was challenging.

Additional Suggested Improvements

In addition to the challenges and corresponding recommendations mentioned above, interviewees offered several other suggestions for improvement:

Training Several interviewees suggested additional, ongoing trainings for MSH staff. Some felt the repetition would help, while others felt they needed some experience to really understand and process what was learned in trainings. Interviewees spoke to the importance of keeping trafficking and trauma on their mind and having opportunities to re-take trainings to solidify skills. This would also help with staff turnover.

> It's good to do the training, have the experience, then going back to the training again, you can see what you could have done differently

Ideas for additional trainings included:

- How to deal with disruptive patients
- Hearing examples of patients and resident experiences to help prepare for encounters
- Ideas for how to ask questions and how to handle different situations that may arise
- Managing mental health
- Weaving all the different MSH training components together
- Front office staff training so they know what to watch for in the clinic waiting room

Language Services Several interviewees suggested better language services or multilingual providers available for patients, as having providers who speak the patient's language can allow easier connections with patients. An interviewee commented that it can be difficult to find therapists that speak patients' home languages, limiting the resources available to them.

Impact of MSH on Healthcare workers

The interviews collected information on how staff are using what they learned in trainings and MSH experiences, and how this contributes to their professional life. The following summarizes this discussion.

Extending Beyond MSH Most interviewees felt they could utilize the skills learned through the MSH clinic outside of the clinic as well, particularly for understanding trauma, being more compassionate, prioritizing patient's needs, and being able to identify other trafficking victims.

> I find it rewarding having the primary care physicians being more comfortable working with severe mental illness; and feeling comfortable providing that specialized level of care; we have a unique training environment, where instead of shuttling patients off to community mental health clinics, we provide better mental health care within our clinic.
>
> - MSH Physician

> I think I have become better at triaging what's most important to patients as opposed to what's important to me. And letting go of what I want for the patient, being able to listen more and sit with discomfort that a patient will bring has made me a better provider overall.
>
> I think it has given our clinic much more compassion for all our patients, not just MSH. It has helped us become more compassionate especially towards much more difficult patients, MSH or not, and allow us to provide good boundaries for ourselves and patients, especially when difficult patient encounters arise.
>
> It has become more applicable to all patients, not just MSH, because everyone comes with trauma by the time I see them as adults, being able to see that, hear that, be compassionate to that has helped me approach people more gently than I might have done as a first-year doctor.
>
> I think just being able to recognize trauma... everyone has gone through some kind of trauma no matter who they are or what they look like... including myself and my colleagues. And trauma does affect how you are and how you carry yourself.
>
> It has heightened my awareness to things like verbal and nonverbal cues, from all patients. There are things now that I look for which help me determine if someone is a trafficking victim, so I'm a better clinician.

Job Satisfaction All interviewees noted that while working with MSH can be difficult work, doing so has positively impacted their job satisfaction.

> It's difficult but rewarding work; I think I love working with some [MSH] patients more than others because their life experiences is so much more… they also are the most challenging patient population because of the trauma they've been through but being able to see progress and have that collaboration in their healthcare was more rewarding than some of my other patients.

> It has increased [my job satisfaction] because you feel like you're doing something important. Helping someone not be trafficked is pretty important.

Preventing Trauma and Burnout While all staff noted working with MSH improved their job satisfaction, they also said working with trafficked victims/survivors could be stressful. Interviewees shared the supports in place at their clinic to address vicarious trauma and ensure staff do not suffer burn out, which seemed to vary depending on the clinic. Supports included ample opportunities to debrief, an open-door policy to discuss with overseeing physicians, and a psychologist on staff at some clinics (Sacramento and Northridge). One interviewee mentioned not knowing what specific supports were available to the staff.

> If it was really rough, we'll have a cry session together. Hearing someone's story you are absorbing some of that trauma. We'll have debrief sessions and the attendings are really good about it. Sometimes we're not ready to talk about it and then we can always talk about it later, there's an open-door policy.

> I feel our clinic is pretty informal, there's no formal process of how to check in with each other, it's usually on our own, and for the most part that works well but for other clinics that might not be the best choice.

> For the MSH in Sacramento, they have a psychologist on staff that would have retreats carved out for resident physicians and weekly time carved out to meet with the psychologist. So, there were opportunities to debrief or decompress individually or as a group.

Partnerships

Partnerships are an important component of the MSH. Each community where the three MSH are located has several organizations working with trafficked victims and survivors. It is through these partnerships that most victims and survivors hear about and/or access MSH services.

Partner Feedback

Community partners are a key aspect to the MSH model. Receiving medical care is often a trigger for trauma victims, with many avoiding care because of the traumatic experience. Community partners are the largest referral source for the MSH and are often the champions for the clinic. The partners can talk with clients about the clinic, assuring the clients that the clinic uses a victim-centered, trauma informed approach and that the MSH is a safe place for care.

Because partnerships are integral to reaching victims and survivors, the evaluation included feedback from MSH community partners. A link to a web-based survey was emailed to 12 partners in September 2021. The email included a hard copy of the survey with instructions to answer the questions as a team prior to entering responses into the web-based survey. This assured that the input was reflective of the team working with the MSH, providing one collective response per organization. In total, 11 organizations (92%) responded: 7 Sacramento MSH partners, and 2 from each the Redding and Northridge MSH.

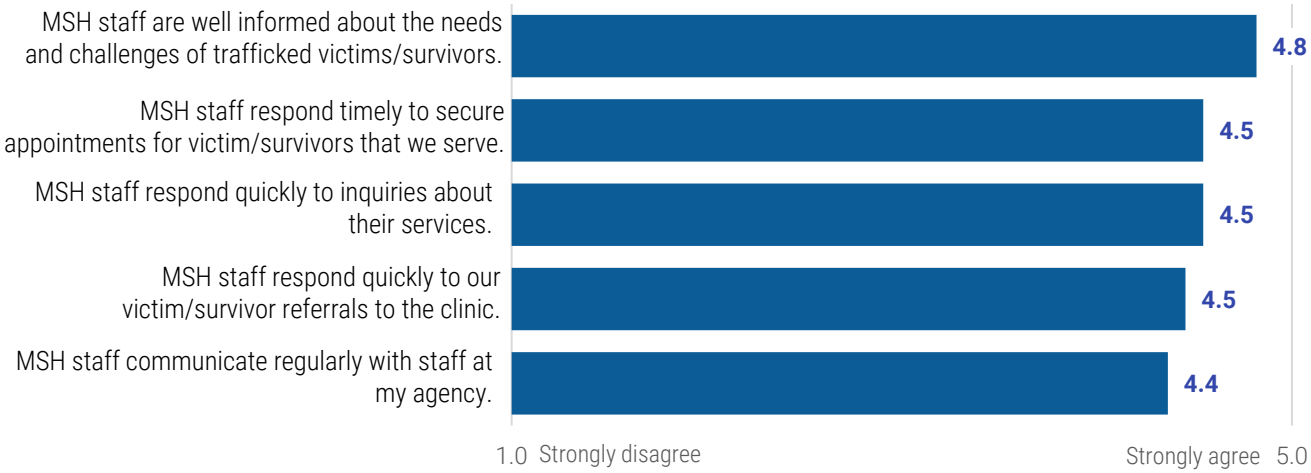
The survey had three sections: 1) the MSH working with Partners, 2) the MSH and the Pandemic, and 3) Partners working with the MSH. These sections included Likert scale questions with opportunity to share "How could this improve?" for each statement as well as other open-ended questions. The following section describes the average scale score for each statement/question and a summary of the qualitative data collected.

MSH Working with Partners

Section one included five statements about the MSH, with partners using a 5-point Likert scale (1=Strong disagree; 5=Strongly agree) to rate their response. Agreement was high for statements related to the MSH working with the partners. The average scores ranged from 4.8 for *"MSH staff are well informed about the needs and challenges of trafficked victims/survivors"* to 4.4 for "*MSH staff communicate regularly with staff at my agency*." See **Figure 19** for details.

The average rating from partners for the MSH were high between 4.4 and 4.8 out of 5.

Figure 19 | Part 1 of Partnership Survey – The MSH, n=11



How could this improve?

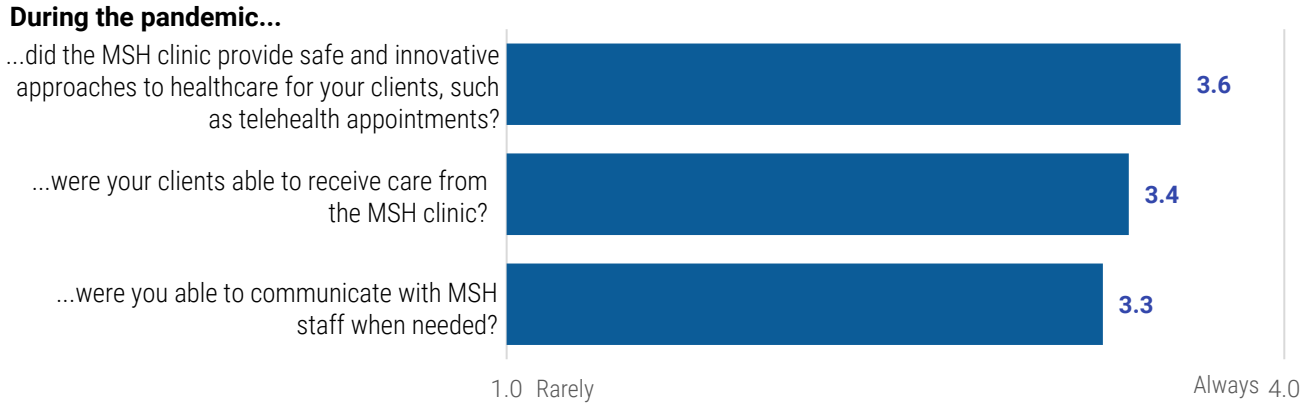
Most of the feedback was about MSH staffing, such as transitions with personnel or staff out on medical or sick leave, which affected response time. It was suggested that the out of office email include alternative contacts to use when people are out to increase response time and urgent messages. Other than this input, feedback was positive, and several agencies mentioned that the response time was great.

> "The scheduled monthly check-ins have been a great asset!"
>
> - MSH Partner

MSH Pandemic-Related Questions

The second section of the survey included pandemic related question about the MSH. This section used a 4-point Likert scale, with 1=Rarely and 4=Always. Partners were asked to respond to three questions about MSH services during the first year of the COVID-19 pandemic (2020). **Figure 20** displays the average score for the three questions, with the highest score to the question "*During the pandemic, did the MSH clinic provide safe and innovative approaches to healthcare for your clients, such as telehealth appointments*?" with the average score of 3.6, followed by "*During the pandemic, were your clients able to receive care from the MSH clinic*?" at 3.4 and "*During the pandemic, were you able to communicate with MSH staff when needed*?" at 3.3.

Figure 20 | Part 2 of Partnership Survey – The Pandemic and the MSH, n=10



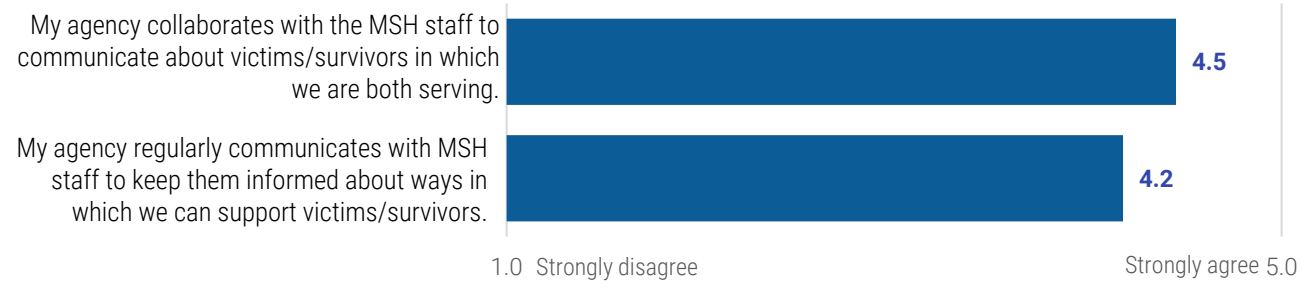
How could this improve?

When asked how this could have improved, there were no responses other than pandemic-related limits on seeing people for in-person care limited clients receiving care in the MSH, which was out of the immediate control of the MSH.

Partners Working with the MSH

Section 3 of the survey included two questions about how the partner works with the MSH, with partners selecting the best response using a 5-point Likert scale, with 1=Strongly disagree and 5=Strongly agree. The partners gave themselves an average score of 4.5 for "*My agency collaborates with the MSH staff to communicate about victims/survivors in which we are both serving*" and 4.2 for "*My agency regularly communicates with MSH staff to keep them informed about ways in which we can support victims/survivors*." (See Figure 21)

Figure 21 | Part 3 of Partnership Survey – The Partner, n=11



How could this improve?

For the above questions, respondents were given the opportunity to make suggestions for improvements. For agencies collaborating with the MSH on victims/survivors they are both serving, the only comment was "On occasions where I have referred clients to MSH I haven't received any communication after the referral, but I wouldn't really expect it due to client confidentiality." And for the question about regular communication between the agency and the MSH, a partner replied,

> There isn't really any mutual communication between our services outside of our/their attendance at the community coalition meeting against trafficking every few months. We all give general updates at that meeting but don't typically collaborate much in between about survivor support.

These two responses suggest that there could be more communication between the agency and the MSH, such as check-ins between the Patient Advocate and Case Managers on the mutually served patients/clients, if patients/clients consent.

Open-ended Questions

The survey included three open-ended questions about what partners are hearing from clients who receive care, about how the MSH is supporting the case manager's role with clients, and overall suggestions for improving the partnership with the MSH. A content analysis was conducted to identify themes which are described below.

Client Feedback on MSH Care Compared to Care Elsewhere

Partners said client feedback was very positive, sharing the "overall approach is great, trauma informed and very supportive for the clients." Most comments were in relation to the MSH staff, such as the "MSH staff are very professional and treat all clients with dignity and respect," "MSH staff are warm and full of valuable knowledge and resources," and "Staff from doctors to those in front desk were friendly, welcoming and trauma informed." One respondent specifically mentioned the Patient Advocate, saying she was "an amazing advocate and always follows up with us even when clients were not able to access services or no longer interested."

In regard to feedback comparing MSH care to care in other practices, there were three comments:

- A client switched her care permanently to the MSH after her first visit.
- The ease of access to care compared to medical facilities where patients often have to spend hours waiting to receive care.
- A client did not feel judged compared to when in a hospital setting.

> "Clients felt they are very patient, and client centered. They have had great follow-up along with listening to their concerns. Clients have felt non-judged compared to other hospital settings."
>
> - MSH Partner

> "Our [client] residents have all expressed how comfortable they feel when receiving care at MSH. Some hesitations in setting up an initial appointment have come from experiences with other medical professionals who were unaware of their background or didn't take it into consideration. The fact that our [client] residents are willing to go and continue going is a testament to the trauma informed care and the true investment of the staff in making sure to serve each patient in their individual needs and background."
>
> - MSH Partner

How MSH supported Case Manager Role with Clients

Survey respondents shared the many ways that the MSH provides support for their roles as case managers, with the number one support being they provide the mental and physical health care treatment their clients need. The cited examples ranged from providing care in a compassionate, caring way to developing treatment plans that work for the client, even providing transportation via Lyft when needed. The MSH's support with psychiatric services and help with prescribed psychiatric medications, along with their guidance on how to navigate health insurance were also mentioned. One partner mentioned the emotional support the Patient Advocate provides is truly valuable.

> Our ladies love all of the doctors and staff there which makes my job easier when I ask if they've had follow-up appointments or would be willing to speak with a doctor about some concerns they have medically or for their mental health. It is also a huge support when the staff is so communicative and collaborative. It doesn't feel like two separate agencies and that is something our team really values about this partnership.
>
> - MSH Partner

> Being able to provide a necessity of getting a wellness exam, getting connected with a psychiatrist, or navigating the insurance has been an asset in the longevity of the client's success.
>
> - MSH Partner

Suggestions to Improve Partnerships

Few partners had suggestions, but several did comment about improvements in communication now that they have bi-weekly or monthly check-in meetings. Comments suggest these meetings are to share updates, concerns, and strategize ways to address problems that may occur, as well as plan outreach and educational efforts.

Partner suggestions included:

1. Offer walk-in appointments or telehealth visits until the client can get an in-person appointment. Sometimes the wait is too long for the immediate need.
2. Provide an alternative person/number to contact when staff are out on leave.
3. Participate in some combined trainings that facilitate equity, diversity, and inclusion to learn more how we can best support each other and survivors.

Conclusion

The MSH evaluation had challenges with delays (starting more than half-way through the funding) and few patients consenting to participate in the evaluation. Due to the low numbers of consenting patients, mental health outcomes for patients were limited. The evaluation of the resident physician training was robust and partner feedback was very positive. Based on what was learned from the evaluation, the evaluation team identified the following key findings, lessons learned, and recommendations.

Key Outcomes

Human Trafficking Education Resident physicians participating in MSH trainings strongly agreed human trafficking education is an important component to resident physician training (4.8 on a 5-point scale).

Trauma Informed Care Resident physicians participating in MSH trainings strongly agreed trauma informed care is important when working with trafficking victims/survivors. (4.8 on a 5-point scale).

Empower Victims Resident physicians participating in MSH trainings "strongly agreed it is essential to empower adult human trafficking victims/survivors to make their own healthcare choices and to support their wishes, safety, and concern. (4.8 on a 5-point scale).

Human Trafficking Indicators Resident physicians participating in MSH trainings "extremely aware" of the potential physical indicators of trafficked victims/survivors. (4.8 on a 5-point scale).

Knowledge and Confidence There was a 75% increase in 3rd year resident physician's knowledge and confidence in working with trafficked victims and survivors.

MSH Program Lessons Learned and Recommendations

Lesson Learned

Comprehensive Resident/Staff Training A comprehensive training program prepares resident physicians and staff for working with human trafficking victims/survivors. Dignity Health currently provides three trainings: an introductory training on the scope, prevalence and types of human trafficking which exist; a training on providing trauma informed care; and a training on building the logistical skills for the patient encounter.

Patient Advocates The Patient Advocate role is vital to the MSH. This highly trained staff person works closely with the clinic staff, victim/survivor patients, and with partner agencies, providing the knowledge of experience and support to navigate health care, insurance, and social service resources. In addition, clinicians reported the Patient Advocate provides useful information that helps the clinician with the exam, such as if the patient is in crisis at the moment.

Extended Appointment Times Feedback from the MSH staff and resident physicians was that the extended appointment times are key to working with this population. Clinicians need time to listen to the patient needs and develop trust, and work with them to feel comfortable with the exam as well as explain future treatment plan options that work for the patient. These are patients that one cannot rush with.

Strong Community Partners Since most of the MSH patients come through referrals from community-based organizations working with this population, it is important to have strong relationships with these organization. The clients they serve trust these organizations, and if the organizations trust the MSH, they are more likely to come in for care. It is also helpful to have knowledge of other community-based organizations, since clients also need other services as well that MSH staff may have to help with, such as basic needs and transportation.

Recommendations

Promote Local Resource List Resident physicians requested a list of local resources to have on hand to share with patients, which Dignity Health has created. A recommendation is to continue to promote and share this resource in trainings.

Create an Avenue for Patient/Client Communication Partners mentioned that there are regular meetings to share program updates, but it was also suggested that there be an avenue for communication about patients the MSH and partner agency are both serving.

MSH Evaluation Recommendations

The evaluation challenges detailed in the Evaluation Limitations section were mostly outside the control of either Dignity Health, the clinics, or LPC and any future evaluation of the MSH may consider the following recommendations.

Retrospective Evaluation Design Consenting MSH clients proved challenging, thus any future MSH evaluation efforts to evaluate patient outcomes should use a retrospective design.

Encourage Consistent Use of Mental Health Assessments One of the focuses on the evaluation was changes in mental health with the plan to use the PCL-5 to measure changes in trauma-related symptoms. Due to challenges consenting patients, the retrospective study was added and included a chart review of the PHQ-9 to assess changes in depression and the GAD-7 to assess changes in anxiety. Few of these assessments were completed even though the patients had documentation of mental health conditions. It is recommended that if Dignity Health plans to assess changes in MSH patients that they encourage more consistent use of these assessments.

The expansion of MSH model to two other California locations provided much needed and supportive services to hundreds of trafficked patients. In addition, Dignity Health trained several cohorts of resident physicians, as well as other healthcare workers and community service organizations to raise awareness of human trafficking, and established and reinforced multiple community partnerships in the three locations. Findings from resident surveys demonstrate increased knowledge and ability to provide patient-centered trauma informed care to not only MSH patients, but to patients they see outside of the MSH and with plans to use this approach throughout their careers. MSH staff expressed the deep impact of working in the MSH, and how it has impacted their practice and view of patients. While implementation of future MSH locations can provide the opportunity to quantitatively assess mental health outcomes of patients, the information shared by patients and staff during interviews and the evaluation findings in this report present a rich and compelling story of innovation and care. For three years filled with challenges no one could have predicted, the Medical Safe Haven has made a positive impact on trafficked patients, MSH resident physicians, MSH staff, and community partners.

Attachments

Attachment A | Prospective Study Data
Attachment B | CARE Measure Data
Attachment C | Retrospective Study: # of Visits and # of Visits with Mental Health Addressed
Attachment D | Retrospective Study: ICD-10 Codes of Cohort
Attachment E | Retrospective Study | PHQ-10 and GAD-7 Score Details
Attachment F | Retrospective Study: Chart Review for Mental Health Status
Attachment G | Resident Training Survey Data
Attachment H | 3rd Year Resident Survey Data
Attachment I | Partner Survey Data

Prospective Study Data

MSH Cohort Intake Data

Client ID	# months with MSH	# appts	Age at Intake	Trafficking types	Age when exploited	Foster care	Children in need of care	# of ED visits	Appt goals
S1	13.5	2	31	Sex		n	n	0	establish care, pregnancy
S2	12	2	18	Sex	18	n	n	1	establish care, pregnancy, meds, STI, injury
S3	12.5	4	35		21	n	y	3	establish care, pregnancy, meds, STI
S4	11	4	18	Sex	10	y	n	3	establish care, meds, STI
S5	11	3	35	Labor	33	n	n	0	establish care, meds
S6	10	3	26	Sex	24	n	n	1	establish care, STI
S7	9	6	30	Sex		y	y	1	establish care, injury, Other: car accident
S8		2	23	Sex	19	y	y	1	establish care, MH, Other: chronic pain, undiagnosed
S9	8	4	30	Sex	13	n	y	3	establish care, meds, Other: post-partum care
S10	5.5	2	36	Sex		y	n	N/A	establish care, MH
S11	5	4	20	Sex	"child"	y	n	N/A	establish care, MH
S12	3	1	37	Sex	21	y	n	0	establish care, Other: thyroid, headaches
R1	7	13	27	Sex	10	n	n	0	establish care
R2	5	1	49	Sex	16	n	n		establish care, meds
N1	8		43	Sex	1	y	n	0	establish care, meds, mental health, STI, injury

MSH Cohort Referrals

	REFERRED								FOLLOWED-UP on REFERRAL						
Client ID	AOD Tx Support	Basic needs	Dental services	Insurance services	Legal services	MH/ Counseling	Specialty medical	Other referral	AOD Tx Support	Basic needs	Dental services	Insurance services	Legal services	MH/ Counseling	Specialty medical
S1															
S2							y								y
S3				y			y					y			y
S4							y								y
S5			y				y								y
S6				y			y					y			y
S7				y			y					y			y
S8							y								y
S9		y		y			y					y			y
S10				y			y					y			y
S11							y								y
S12							y								n
R1			y	y			y				y	y			y
R2		y					y			y					
N1				y								y			

Attachment A

MSH Cohort PCL-5 Scores

Client ID	#1 PCL-5 Date	#1 PCL-5 Score	#2 PCL-5 Date	#2 PCL-5 Score
S1	7/22/2020	67.5		
S2	8/27/2020	54.0		
S3	5/27/2021	1.0		
S4				
S5	10/15/2020	20.0		
S6	11/5/2020	4.0		
S7	12/9/2020	58.0		
S8	12/10/2020	36.0		
S9	1/7/2021	30.0		
S10	3/17/2021	36.0		
S11	3/24/2021	34.0	6/24/21	13.0
S12	5/27/2021	7.0		
R1	1/26/2021	60.0	8/16/21	49.0
R2	3/30/2021	72.0		
N1	7/16/2021	37.0		

Prospective Study | CARE Measure Data

Score by Question for Each Respondent

Patient location	Making you feel at ease	Letting you tell your story	Listening & understanding	Showing care & compassion	Helping you take control
Northridge	5	5	5	5	5
Redding	4	4	4	4	4
Redding	4	5	4	4	4
Redding	5	5	5	5	5
Redding	5	5	5	5	5
Redding	4	4	4	4	4
Redding	5	5	5	5	5
Sacramento	5	5	5	4	5
Sacramento	5	5	5	5	5
Sacramento	5	5	5	5	5
Sacramento	4	4	4	5	4
Sacramento	5	5	5	5	5
Sacramento	5	5	5	5	5
Sacramento	5	5	5	5	5
Sacramento	5	5	5	5	4
Sacramento	5	5	5	5	5
Sacramento	5	5	5	5	5
Sacramento	3	5	3	3	4
Sacramento	5	5	5	5	5
Sacramento	5	5	5	5	5
Sacramento	5	5	5	5	5
Sacramento	5	5	4	5	5
Sacramento	3	3	3	3	3

Retrospective Study | Mental Health Data

of Visits and # of Visits with Mental Health Addressed

ID	# of visits to MSH	# of visits MH was addressed	% appointments with MH addressed
1	3	0	0%
2	3	1	33%
3	3	2	67%
4	3	2	67%
5	4	2	50%
6	4	3	75%
7	4	3	75%
8	4	3	75%
9	4	3	75%
10	4	4	100%
11	4	4	100%
12	5	2	40%
13	5	3	60%
14	5	4	80%
15	5	5	100%
16	6	2	33%
17	6	4	67%
18	6	6	100%
19	6	6	100%
20	7	3	43%
21	8	3	38%
22	8	4	50%
23	8	5	63%
24	8	8	100%
25	9	1	11%

ID	# of visits to MSH	# of visits MH was addressed	% appointments with MH addressed
26	10	2	20%
27	10	7	70%
28	10	7	70%
29	11	2	18%
30	11	8	73%
31	11	9	82%
32	12	8	67%
33	12	12	100%
34	13	2	15%
35	13	12	92%
36	14	2	14%
37	14	6	43%
38	16	13	81%
39	18	18	100%
40	19	1	5%
41	19	7	37%
42	19	19	100%
43	20	4	20%
44	23	13	57%
45	23	23	100%
46	25	23	92%
47	39	30	77%
48	49	23	47%
49	64	56	88%

Retrospective Study | ICD-10 Codes

Broad Categories for Retrospective Cohort

1st digit	Diagnosis Code	#	%
F	Mental, Behavioral and Neurodevelopmental disorders	41	87%
T	Injury, Poisoning, Certain Other Consequences of External Causes	27	57%
Z	Factors Influencing Health Status and Contact with Health Services	27	57%
G	Nervous System	11	23%
R	Symptoms, Signs and Abnormal Clinical and Lab Findings	5	11%
Y	External Causes of Morbidity	5	11%
S	Injury, Poisoning, Certain Other Consequences of External Causes	2	4%
N	Genitourinary System	1	2%
O	Pregnancy, Childbirth and the Puerperium	1	2%

Attachment D

ICD-10 Codes | Categories based on First 3 digits for Retrospective Cohort

1st 3 digits	Diagnosis Code	#	%
F43	Reaction to severe stress, and adjustment disorders	30	64%
T74	Adult & child abuse, neglect & other maltreatment, confirmed	24	51%
F41	Other anxiety disorders	20	43%
Z65	Problems related to other psychosocial circumstances	16	34%
F32	Depressive episode	14	30%
G47	Sleep disorder	11	23%
F19	Other psychoactive substance related disorders	9	19%
Z91	Personal risk factors	9	19%
F11	Opioid related disorders	8	17%
F31	Bipolar disorder	7	15%
Z04	Encounter for examination and observation for other reasons	6	13%
Z87	Personal history of other diseases and conditions	6	13%
F15	Other stimulant related disorders	5	11%
Y07	Perpetrator of assault, maltreatment and neglect	5	11%
F51	Sleep disorders not due to a substance or known physiological condition	4	9%
F10	Alcohol related disorders	3	6%
R45	Symptoms and signs involving emotional state	3	6%
T76	Adult and child abuse, neglect and other maltreatment, suspected	3	6%
R53	Malaise and fatigue	2	4%
T50	Poisoning by, adverse effect of and underdosing of diuretics and other and unspecified drugs, medicaments and biological substances	2	4%
Z51	Encounter for other aftercare and medical care	2	4%
Z72	Problems related to lifestyle	2	4%
F12	Cannabis related disorders	1	2%
F20	Schizophrenia	1	2%
F25	Schizoaffective disorders	1	2%
F33	Major depressive disorder, recurrent	1	2%
F34	Persistent mood [affective] disorders	1	2%
F39	Unspecified mood [affective] disorder	1	2%
F44	Dissociative and conversion disorders	1	2%
F60	Specific personality disorders	1	2%
F99	Mental disorder, not otherwise specified	1	2%
N94	Pain and other conditions associated with female genital organs and menstrual cycle	1	2%
O99	Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium	1	2%
R41	Other symptoms and signs involving cognitive functions and awareness	1	2%
R44	Other symptoms and signs involving general sensations and perceptions	1	2%
S09	Other and unspecified injuries of head	1	2%
S36	Injury of intra-abdominal organs	1	2%
Z59	Problems related to housing and economic circumstances	1	2%
Z62	Problems related to upbringing	1	2%
Z63	Other problems related to primary support group, including family circumstances	1	2%
Z86	Personal history of certain other diseases	1	2%

1st 3 digits	Diagnosis Code	#	%
Z92	Personal history of medical treatment	1	2%

ICD-10 Codes | Full ICD-10 Codes for Retrospective Cohort

Full Code	Diagnosis Code	#	%
F43.10	Post-traumatic stress disorder, unspecified	21	45%
F41.9	Anxiety disorder, unspecified	16	34%
Z65.4	Victim of crime and terrorism	15	32%
F32.9	Major depressive disorder, single episode, unspecified	14	30%
T74.51XA	Adult forced sexual exploitation, confirmed, initial encounter	12	26%
F43.12	Post-traumatic stress disorder, chronic	11	23%
G47.00	Insomnia, unspecified	11	23%
F31.9	Bipolar disorder, unspecified	6	13%
Z04.81	Encounter for examination and observation of victim following forced sexual exploitation	6	13%
Y07.6	Multiple perpetrators of maltreatment and neglect	5	11%
Z91.410	Personal history of adult physical and sexual abuse	5	11%
F11.20	Opioid dependence, uncomplicated	4	9%
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder	4	9%
F19.20	Other psychoactive substance dependence, uncomplicated	4	9%
F41.1	Generalized anxiety disorder	4	9%
T74.91XA	Unspecified adult maltreatment, confirmed, initial encounter	4	9%
Z87.898	Personal history of other specified conditions	4	9%
F19.11	Other psychoactive substance abuse, in remission	3	6%
F19.90	Other psychoactive substance use, unspecified, uncomplicated	3	6%
F41.8	Other specified anxiety disorders	3	6%
F51.5	Nightmare disorder	3	6%
T74.21XA	Adult sexual abuse, confirmed, initial encounter	3	6%
Z91.42	Personal history of forced labor or sexual exploitation	3	6%
F10.10	Alcohol abuse, uncomplicated	2	4%
F10.20	Alcohol dependence, uncomplicated	2	4%
F10.21	Alcohol dependence, in remission	2	4%
F11.10	Opioid abuse, uncomplicated	2	4%
F11.90	Opioid use, unspecified, uncomplicated	2	4%
F15.10	Other stimulant abuse, uncomplicated	2	4%
F19.10	Other psychoactive substance abuse, uncomplicated	2	4%
F41.0	Panic disorder [episodic paroxysmal anxiety]	2	4%
R45.851	Suicidal ideations	2	4%
R53.83	Other fatigue	2	4%
T74.51XD	Adult forced sexual exploitation, confirmed, subsequent encounter	2	4%
T74.61XA	Adult forced labor exploitation, confirmed, initial encounter	2	4%
T76.51XA	Adult forced sexual exploitation, suspected, initial encounter	2	4%
Z51.81	Encounter for therapeutic drug level monitoring	2	4%
F11.11	Opioid abuse, in remission	1	2%
F11.29	Opioid dependence with unspecified opioid-induced disorder	1	2%
F11.9	Opioid use, unspecified	1	2%

Full Code	Diagnosis Code	#	%
F12.90	Cannabis use, unspecified, uncomplicated	1	2%
F15.11	Other stimulant abuse, in remission	1	2%
F15.20	Other stimulant dependence, uncomplicated	1	2%
F15.23	Other stimulant dependence with withdrawal	1	2%
F19.2	Other psychoactive substance dependence	1	2%
F20.9	Schizophrenia, unspecified	1	2%
F25.9	Schizoaffective disorder, unspecified	1	2%
F31.81	Bipolar II disorder	1	2%
F32.1	Major depressive disorder, single episode, moderate	1	2%
F33.1	Major depressive disorder, recurrent, moderate	1	2%
F34.9	Persistent mood [affective] disorder, unspecified	1	2%
F39	Unspecified mood [affective] disorder	1	2%
F44.9	Dissociative and conversion disorder, unspecified	1	2%
F51.02	Adjustment insomnia	1	2%
F60.9	Personality disorder, unspecified	1	2%
F99	Mental disorder, not otherwise specified	1	2%
N94.10	Unspecified dyspareunia	1	2%
O99.345	Other mental disorders complicating the puerperium	1	2%
O99.891	Other specified diseases and conditions complicating pregnancy	1	2%
R41.0	Disorientation, unspecified	1	2%
R44.1	Visual hallucinations	1	2%
R45.86	Emotional lability	1	2%
S09.90XA	Unspecified injury of head, initial encounter	1	2%
S36.60XA	Unspecified injury of rectum, initial encounter	1	2%
T50.5X5A	Adverse effect of appetite depressants, initial encounter	1	2%
T50.905A	Adverse effect of unspecified drugs, medicaments and biological substances, initial encounter	1	2%
T74.11XA	Adult physical abuse, confirmed, initial encounter	1	2%
T74.22XA	Child sexual abuse, confirmed, initial encounter	1	2%
T74.31XA	Adult psychological abuse, confirmed, initial encounter	1	2%
T74.32XA	Child psychological abuse, confirmed, initial encounter	1	2%
T74.51XS	Adult forced sexual exploitation, confirmed, sequela	1	2%
T74.52XA	Child sexual exploitation, confirmed, initial encounter	1	2%
T74.52XS	Child sexual exploitation, confirmed, sequela	1	2%
T74.61XD	Adult forced labor exploitation, confirmed, subsequent encounter	1	2%
T74.62XA	Child forced labor exploitation, confirmed, initial encounter	1	2%
T76.61XA	Adult forced labor exploitation, suspected, initial encounter	1	2%
Z59.9	Problem related to housing and economic circumstances, unspecified	1	2%
Z62.819	Personal history of unspecified abuse in childhood	1	2%
Z63.0	Problems in relationship with spouse or partner	1	2%
Z65.9	Problem related to unspecified psychosocial circumstances	1	2%
Z72.51	High risk heterosexual behavior	1	2%
Z72.89	Other problems related to lifestyle	1	2%
Z86.59	Personal history of other mental and behavioral disorders	1	2%
Z87.59	Personal history of other complications of pregnancy, childbirth and the puerperium	1	2%

Full Code	Diagnosis Code	#	%
Z87.828	Personal history of other (healed) physical injury and trauma	1	2%
Z91.89	Other specified personal risk factors, not elsewhere classified	1	2%
Z92.29	Personal history of other drug therapy	1	2%

Retrospective Study | PHQ-9 and GAD-7 Score Details

PHQ-9 Score Details

ID	Baseline, n=12	Follow-up, n=4
1	1	-
2	7	-
3	8	19
4	10	19
5	14	-
6	15	-
7	15	-
8	17	14
9	19	-
10	20	22
11	21	-
12	24	-

GAD-7 Score Details

ID	Baseline, n=8	Follow-up, n=1
1	11	-
2	14	-
3	14	17
4	15	-
5	17	-
6	18	-
7	19	-
8	21	-

Retrospective Study | Chart Review Data

Visit # and # of Patients with Mental Health Addressed for 1st 12 Visits

Visit #	# with MH addressed	% with MH addressed	Total patients
1	41	84%	49
2	38	78%	49
3	24	49%	49
4	26	58%	45
5	24	65%	37
6	19	56%	34
7	17	57%	30
8	18	62%	29
9	10	40%	25
10	11	46%	24
11	13	62%	21
12	12	67%	18

Noted Mental Health Change Compared to Previous Visit for 1st 12 visits

	Number			Percent		
Visit #	Improved	Declined	No change	Improved	Declined	No change
1	-	-	-	-	-	-
2	11	8	16	31%	23%	46%
3	10	2	9	48%	10%	43%
4	8	10	7	32%	40%	28%
5	5	7	11	22%	30%	48%
6	4	5	8	24%	29%	47%
7	4	2	10	25%	13%	63%
8	7	1	10	39%	6%	56%
9	3	1	3	43%	14%	43%
10	3	3	5	27%	27%	45%
11	3	3	6	25%	25%	50%
12	1	4	8	8%	31%	62%

Training Survey Survey Data

MSH HT Training data, Part I

ID	Training Location:	Training Date:	What best describes you?	Which year?	BEFORE TRAINING							NOW						
					The scope of human trafficking in the United States and worldwide.	Commercial sexual activity is considered human trafficking, whether forced or voluntary if the individual is less than 18 years of age.	The Industries where Labor and Sex trafficking most often occur.	The indicators that may signify trafficking.	The physical indicators of a trafficked victim/ survivor.	The impact of chronic trauma on the brain and symptomology.	The Human Trafficking takes place in my own community.	The scope of human trafficking in the United States and worldwide.	Commercial sexual activity is considered human trafficking, whether forced or voluntary if the individual is less than 18 years of age.	The Industries where Labor and Sex trafficking most often occur.	The indicators that may signify trafficking.	The physical indicators of a trafficked victim/survivor).	The impact of chronic trauma on the brain and symptomology.	The Human Trafficking takes place in my own community.
2	Sac	06/24/2020	Resident	PGY-1	2	2	3	3	3	4	3	4	5	5	5	4	4	5
3	Sac	06/24/2020	Resident	PGY-1	4	4	3	3	3	3	3	5	5	5	5	5	5	5
4	Sac	06/24/2020	Resident	PGY-1	2	2	2	1	1	4	2	4	5	4	4	4	5	4
5	Sac	06/24/2020	Resident	PGY-1	3	2	3	3	3	3	3	4	5	4	4	4	4	5
6	Nor	09/23/2020	Resident	PGY-1	3	4	3	3	3	4	4	4	4	4	4	4	4	4
7	Nor	09/23/2020	Resident	PGY-1	3	3	3	3	3	3	3	4	4	4	4	4	5	5
8	Nor	09/23/2020	Resident	PGY-1	4	3	3	4	4	4	3	5	4	4	5	5	5	4
9	Nor	09/23/2020	Resident	PGY-2	3	3	2	4	2	4	4	4	5	3	4	4	5	5
10	Nor	09/23/2020	Resident	PGY-2	2	2	2	2	1	3	4	4	4	3	4	3	4	4
11	Nor	09/23/2020	Resident	PGY-2	3	2	3	2	2	2	3	5	4	4	4	4	5	5
12	Nor	09/23/2020	Resident	PGY-2	5	2	2	4	4	5	4	5	4	3	4	4	5	4
13	Nor	09/23/2020			5	5	3	4	4	5	5	5	5	4	4	4	5	5
14	Nor	09/23/2020	Resident	PGY-3	2	1	2	2	1	1	2	3	3	3	4	3	4	5
15	Nor	09/23/2020	Resident	PGY-3	4	4	3	4	4	4	5	5	4	3	4	4	4	5
16	Nor	09/23/2020	Resident	PGY-3	3	5	2	3	3	4	3	5	5	4	4	4	5	4
17	Nor	09/23/2020	Resident	PGY-3	3	2	2	3	3	4	2	4	4	4	4	4	5	4
18	Nor	09/23/2020	Resident	PGY-3	4	4	4	4	4	3	4	4	4	4	4	4	4	4
19	Nor	09/23/2020	Resident	PGY-3	3	1	2	3	1	3	2	4	4	4	4	4	4	4
20	Nor	09/23/2020			4	4	3	4	4	3	2	5	5	4	5	5	4	3
21	Nor	09/23/2020	Other		2	4	2	3	2	4	3	3	4	2	3	3	5	4
22	Nor	09/23/2020	Other		2	2	2	1	2	3	2	4	4	4	4	4	4	4
23	Sac	06/30/2021	Resident	PGY-1	3	4	2	3	2	3	3	4	4	4	4	4	4	4
24	Sac	06/30/2021	Resident	PGY-1	3	5	3	3	3	3	3	5	5	4	4	4	4	5
25	Sac	06/30/2021	Resident		3	5	2	2	3	2	2	4	5	5	4	5	5	5
26	Sac	06/30/2021	Resident	PGY-1	3	2	3	3	3	3	2	5	4	5	5	5	5	5
27	Sac	06/30/2021	Resident	PGY-1	3	4	2	3	2	3	2	4	5	5	4	4	5	5
28	Sac	06/30/2021	Resident	PGY-1	3	3	2	3	3	4	2	5	5	5	5	5	5	5
29	Sac	06/30/2021	Resident	PGY-1	2	3	1	2	2	3	4	4	5	5	5	4	4	5
30	Sac	06/30/2021	Resident	PGY-1	4	3	3	2	1	2	4	5	5	5	5	5	5	5
32	Nor	07/23/2021	Resident	PGY-1	3	5	3	3	3	4	4	4	5	4	4	4	4	5
33	Nor	07/23/2021	Resident	PGY-3	4	5	3	3	2	1	4	5	5	5	5	4	3	5
34	Nor	07/23/2021	Other		5	4	4	3	3	3	4	5	4	4	3	4	4	4

Attachment G

					BEFORE TRAINING							NOW						
ID	Training Location:	Training Date:	What best describes you?	Which year?	The scope of human trafficking in the United States and worldwide.	Commercial sexual activity is considered human trafficking, whether forced or voluntary if the individual is less than 18 years of age.	The Industries where Labor and Sex trafficking most often occur.	The indicators that may signify trafficking.	The physical indicators of a trafficked victim/ survivor.	The impact of chronic trauma on the brain and symptomology.	The Human Trafficking takes place in my own community.	The scope of human trafficking in the United States and worldwide.	Commercial sexual activity is considered human trafficking, whether forced or voluntary if the individual is less than 18 years of age.	The Industries where Labor and Sex trafficking most often occur.	The indicators that may signify trafficking.	The physical indicators of a trafficked victim/survivor).	The impact of chronic trauma on the brain and symptomology.	The Human Trafficking takes place in my own community.
35	Nor	07/23/2021	Other		3	3	3	3	3	3	3	5	5	5	5	5	5	5
36	Nor	07/23/2021	Other		3	3	3	3	3	3	3	4	4	4	4	4	4	4
37	Nor	07/23/2021	Resident	PGY-1	2	4	1	1	2	4	1	5	5	5	5	5	5	5
38	Nor	07/23/2021	Resident		2	5	3	2	4	1	5	5	5	5	5	5	1	5
39	Nor	07/23/2021	Resident		3	4	3	3	3	3	3	4	4	4	4	4	4	4
40	Nor	07/23/2021	Resident	PGY-1	4	4	3	5	4	5	2	5	5	4	5	5	5	3
41	Red	08/11/2021	Resident	PGY-3	3	4	4	3	4	4	4							
42	Red	08/11/2021	Resident	PGY-1	3	3	2	1	1	1	1	4	5	4	3	3	3	3
43	Red	08/11/2021	Resident	PGY-1	5	4	2	2	2	4	4	5	5	5	4	4	5	5
44	Red	08/11/2021	Resident	PGY-1	2	3	1	2	2	4	3	4	5	5	4	4	4	5
45	Red	08/11/2021	Resident	PGY-2	4	4	3	3	4	4	2	4	4	4	4	4	4	4
46	Red	08/11/2021	Resident	PGY-1	3	4	4	3	4	4	3	5	5	5	5	5	5	5
47	Red	08/11/2021	Resident	PGY-1	4	4	4	4	4		4				5	5		5
48	Red	08/11/2021	Resident	PGY-2	3	3	1	2	2	2	1	5	5	5	5	5	5	5
49	Red	08/11/2021	Resident	PGY-1	3	2	2	2	2	1	1	5	5	5	5	5	5	5

MSH HT Training data, Part I|

ID	Training Location:	Training Date:	What best describes you?	Which year?	BEFORE TRAINING				NOW			
					Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	If I identify a human trafficking victim I know where to find community and national resources for the victim.	I believe it is essential to empower adult human trafficking victims to make their own choices regarding their trafficking situation.	Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	If I identify a human trafficking victim I know where to find community and national resources for the victim.	I believe it is essential to empower adult human trafficking victims to make their own choices regarding their trafficking situation.
2	Sac	06/24/2020	Resident	PGY-1	4	2	2	3	5	4	4	4
3	Sac	06/24/2020	Resident	PGY-1	5	4	3	5	5	5	5	5
4	Sac	06/24/2020	Resident	PGY-1	3	2	2	4	4	4	4	5
5	Sac	06/24/2020	Resident	PGY-1	5	4	4	5	5	5	5	5
6	Nor	09/23/2020	Resident	PGY-1	4	3	3	4	5	4	4	5
7	Nor	09/23/2020	Resident	PGY-1	4	4	4	4	4	4	5	5
8	Nor	09/23/2020	Resident	PGY-1	4	2	2	5	5	4	4	5
9	Nor	09/23/2020	Resident	PGY-2								
10	Nor	09/23/2020	Resident	PGY-2	5	2	2	5	5	3	4	5
11	Nor	09/23/2020	Resident	PGY-2	3	3	2	3	5	4	3	4
12	Nor	09/23/2020	Resident	PGY-2	5	3	2	4	5	4	3	4
13	Nor	09/23/2020			5	4	2	3	5	4	4	5
14	Nor	09/23/2020	Resident	PGY-3	4	3	2	5	5	4	3	5
15	Nor	09/23/2020	Resident	PGY-3	4	4	4	4	4	4	4	4
16	Nor	09/23/2020	Resident	PGY-3	5	2	2	4	5	4	4	5
17	Nor	09/23/2020	Resident	PGY-3	5	3	2	5	5	5	5	5
18	Nor	09/23/2020	Resident	PGY-3	4	4	3	4	5	4	4	5
19	Nor	09/23/2020	Resident	PGY-3	3	2	2	3	4	4	4	4
20	Nor	09/23/2020			4	4	2	4	5	5	3	4
21	Nor	09/23/2020	Other		5	2	2	5	5	3	3	5
22	Nor	09/23/2020	Other		4	2	2	4	5	4	4	5
23	Sac	06/30/2021	Resident	PGY-1	4	2	2	4	5	4	4	4
24	Sac	06/30/2021	Resident	PGY-1	5	3	2	5	5	4	4	5
25	Sac	06/30/2021	Resident		5	2	2	5	5	4	4	5
26	Sac	06/30/2021	Resident	PGY-1	5	3	3	3	5	5	5	5
27	Sac	06/30/2021	Resident	PGY-1	5	2	2	5	5	3	3	5
28	Sac	06/30/2021	Resident	PGY-1	5	3	2	5	5	4	5	5
29	Sac	06/30/2021	Resident	PGY-1	5	3	2	5	5	4	3	5
30	Sac	06/30/2021	Resident	PGY-1	5	3	3	5	5	4	4	5
32	Nor	07/23/2021	Resident	PGY-1								
33	Nor	07/23/2021	Resident	PGY-3	4	4	2	4	5	5	5	5
34	Nor	07/23/2021	Other									
35	Nor	07/23/2021	Other		5	4	2	5	5	5	5	5
36	Nor	07/23/2021	Other		3	3	3	3	5	5	5	5
37	Nor	07/23/2021	Resident	PGY-1	4	4	4	5	5	5	5	5
38	Nor	07/23/2021	Resident									
39	Nor	07/23/2021	Resident		3	3	3	3	4	4	4	4
40	Nor	07/23/2021	Resident	PGY-1	5	4	2	5	5	5	4	5
41	Red	08/11/2021	Resident	PGY-3	4	4	4	4				
42	Red	08/11/2021	Resident	PGY-1	3	1	1	4	4	3	3	5

Attachment G

ID	Training Location:	Training Date:	What best describes you?	Which year?	BEFORE TRAINING				NOW			
					Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	If I identify a human trafficking victim I know where to find community and national resources for the victim.	I believe it is essential to empower adult human trafficking victims to make their own choices regarding their trafficking situation.	Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	If I identify a human trafficking victim I know where to find community and national resources for the victim.	I believe it is essential to empower adult human trafficking victims to make their own choices regarding their trafficking situation.
43	Red	08/11/2021	Resident	PGY-1	5	3	2	5	5	4	2	5
44	Red	08/11/2021	Resident	PGY-1	4	2	1	4	4	3	2	5
45	Red	08/11/2021	Resident	PGY-2	5	3	3	5	5	3	3	5
46	Red	08/11/2021	Resident	PGY-1	5	3	3	5	5	4	5	5
47	Red	08/11/2021	Resident	PGY-1	5	4	4	4	5	5	5	5
48	Red	08/11/2021	Resident	PGY-2	5	4	5	5	5	5	5	5
49	Red	08/11/2021	Resident	PGY-1	5	3	3	5	5	4	4	5

MSH HT Training data, Part III

ID	Training Location:	Training Date:	What best describes you?	Which year?	I would recommend this training to other resident physicians.	I learned new information from this training.	The trainer was knowledgeable on the subject manner.
2	Sac	06/24/2020	Resident	PGY-1	4	5	5
3	Sac	06/24/2020	Resident	PGY-1	5	5	5
4	Sac	06/24/2020	Resident	PGY-1	5	5	5
5	Sac	06/24/2020	Resident	PGY-1	5	5	5
6	Nor	09/23/2020	Resident	PGY-1	5	5	5
7	Nor	09/23/2020	Resident	PGY-1	4	5	5
8	Nor	09/23/2020	Resident	PGY-1	5	5	5
9	Nor	09/23/2020	Resident	PGY-2			
10	Nor	09/23/2020	Resident	PGY-2	5	5	5
11	Nor	09/23/2020	Resident	PGY-2	5	5	5
12	Nor	09/23/2020	Resident	PGY-2	5	5	5
13	Nor	09/23/2020			5	5	5
14	Nor	09/23/2020	Resident	PGY-3	5	5	5
15	Nor	09/23/2020	Resident	PGY-3	4	4	4
16	Nor	09/23/2020	Resident	PGY-3	4	5	5
17	Nor	09/23/2020	Resident	PGY-3	5	5	5
18	Nor	09/23/2020	Resident	PGY-3	5	4	5
19	Nor	09/23/2020	Resident	PGY-3	4	5	5
20	Nor	09/23/2020			4	4	5
21	Nor	09/23/2020	Other		5	5	5
22	Nor	09/23/2020	Other		4	5	5
23	Sac	06/30/2021	Resident	PGY-1	5	5	5
24	Sac	06/30/2021	Resident	PGY-1	5	5	5
25	Sac	06/30/2021	Resident		5	5	5
26	Sac	06/30/2021	Resident	PGY-1	5	5	5
27	Sac	06/30/2021	Resident	PGY-1	5	5	5
28	Sac	06/30/2021	Resident	PGY-1	5	5	5
29	Sac	06/30/2021	Resident	PGY-1	5	5	5
30	Sac	06/30/2021	Resident	PGY-1	5	5	5
32	Nor	07/23/2021	Resident	PGY-1			
33	Nor	07/23/2021	Resident	PGY-3	5	5	5
34	Nor	07/23/2021	Other				
35	Nor	07/23/2021	Other		5	5	5
36	Nor	07/23/2021	Other		4	4	4
37	Nor	07/23/2021	Resident	PGY-1	4	4	5
38	Nor	07/23/2021	Resident				
39	Nor	07/23/2021	Resident		4	4	4
40	Nor	07/23/2021	Resident	PGY-1	4	4	5
41	Red	08/11/2021	Resident	PGY-3	4	4	5
42	Red	08/11/2021	Resident	PGY-1	4	5	5
43	Red	08/11/2021	Resident	PGY-1	5	5	5
44	Red	08/11/2021	Resident	PGY-1	4	5	5
45	Red	08/11/2021	Resident	PGY-2	5	5	5
46	Red	08/11/2021	Resident	PGY-1	5	5	5
47	Red	08/11/2021	Resident	PGY-1	5	5	5
48	Red	08/11/2021	Resident	PGY-2	5	5	5
49	Red	08/11/2021	Resident	PGY-1	5	5	5

TIC Resident Training data, Part I

					BEFORE TRAINING						NOW					
ID	Training Location:	Training Date:	What best describes you?	Which year?	The potential physical indicators of a trafficked victim/survivor.	The long-term impacts of trauma bonding on victims/survivors and how it can affect choices they make.	Victims/survivors can be triggered and/or retraumatized during routine healthcare visits.	The impact of chronic trauma on the brain and symptomology.	The importance of putting victim/survivor's wishes, safety, and well-being as a priority.	The scope and impact of trauma, including Adverse Childhood Experiences (ACES').	The potential physical indicators of a trafficked victim/survivor.	The long-term impacts of trauma bonding on victims/survivors and how it can affect choices they make.	Victims/survivors can be triggered and/or retraumatized during routine healthcare visits.	The impact of chronic trauma on the brain and symptomology.	The importance of putting victim/survivor's wishes, safety, and well-being as a priority.	The scope and impact of trauma, including Adverse Childhood Experiences (ACES').
4	Sac	08/26/2020	Resident	PGY-2	2	1	2	2	5	3	4	4	5	4	5	4
6	Sac	12/09/2020	Resident	PGY-3	4	4	4	3	5	5	5	5	5	4	5	5
7	Sac	12/09/2020	Resident	PGY-3	4	4	4	4	4	4	5	5	5	5	5	5
8	Sac	08/26/2020	Resident	PGY-2	3	4	4	4	5	5	4	4	5	5	5	5
9	Sac	08/26/2020	Resident	PGY-1	3	3	4	4	5	4	5	5	5	5	5	5
10	Sac	08/26/2020	Resident	PGY-1	4	4	3	4	3	4	4	4	5	5	5	4
11	Sac	08/26/2020	Resident	PGY-1	4	4	4	4	4	4	4	4	4	4	4	4
12	Sac	08/26/2020	Resident	PGY-1	2	3	2	3	5	4	5	5	5	5	5	5
13	Sac	08/26/2020	Other		2	3	3	3	2	3	4	4	5	5	4	4
14	Sac	08/26/2020	Other		3	3	4	3	4	4	4	4	4	4	4	4
15	Sac	08/26/2020	Resident	PGY-1	3	4	4	4	5	4	4	4	5	5	5	5
16	Sac	08/26/2020	Resident	PGY-1	4	4	4	4	5	4	5	5	5	5	5	5
17	Sac	08/26/2020	Resident	PGY-1	4	4	4	4	5	4	5	5	5	5	5	5
18	Nor	03/09/2021	Resident	PGY-2	4	4	4	4	4	4	5	5	5	5	5	5
19	Nor	03/09/2021	Resident	PGY-1	3	3	4	3	4	3	4		5	4	5	4
21	Nor	03/09/2021	Resident	PGY-3	4	3	4	3	5	4	4	4	5	3	5	4
22	Nor	03/09/2021	Resident	PGY-3	3	3	3	4	4	4	4	4	4	4	4	4
23	Red	03/10/2021	Resident	PGY-2	3	4	3	3	4	4	4	4	4	4	5	4
24	Red	03/10/2021	Other		3	3	3	3	3	4	4	4	4	4	4	4
25	Red	03/10/2021	Resident	PGY-1	3	4	4	4	5	2	4	4	5	4	5	3
26	Red	03/10/2021	Resident	PGY-2	4	5	5	5	5	5	5	5	5	5	5	5
27	Red	03/10/2021	Resident	PGY-3	4	4	4	4	4	4	5	5	5	4	5	5
28	Nor	03/09/2021	Resident	PGY-1	4	5	5	5	5	5	4	5	5	5	5	5
29	Nor	03/09/2021	Resident	PGY-1	3	5	5	5	5	4	4	5	5	5	5	5
32	Nor	03/09/2021	Other		4	4	4	4	5	4	5		5	4	5	5
33	Nor	03/09/2021	Resident	PGY-1	3	4	3	3	4	4	4	5	4	4	5	4
38	Nor	03/09/2021	Resident	PGY-3	4	4	4	4	4	4	5	5	5	5	5	5
39	Red	03/10/2021	Resident	PGY-3	3	3	4	3	4	4	4	4	5	4	5	5
41	Nor	03/09/2021	Other		5	5	5	4	5	5	5	5	5	4	5	5
42	Red	03/10/2021	Resident	PGY-3	3	3	3	3	3	4	4	4	4	4	4	5
43	Red	03/10/2021	Resident	PGY-1	4	4	2	3	4	3	4	4	4	4	5	5
44	Red	03/10/2021	Resident	PGY-1	4	4	4	4	4	3	5	5	5	5	5	5
46	Nor	07/23/2021	Resident		3	3	3	3	3	3	4	4	4	4	4	4
47	Nor	07/23/2021	Resident	PGY-1	4	5	5	5	5		5	5	5	5	5	5
48	Nor	07/23/2021	Resident	PGY-1	2	2	5	1	5	2	5	5	5	1	5	3

Attachment G

					BEFORE TRAINING						NOW					
ID	Training Location:	Training Date:	What best describes you?	Which year?	The potential physical indicators of a trafficked victim/survivor.	The long-term impacts of trauma bonding on victims/survivors and how it can affect choices they make.	Victims/survivors can be triggered and/or retraumatized during routine healthcare visits.	The impact of chronic trauma on the brain and symptomology.	The importance of putting victim/survivor's wishes, safety, and well-being as a priority.	The scope and impact of trauma, including Adverse Childhood Experiences (ACES').	The potential physical indicators of a trafficked victim/survivor.	The long-term impacts of trauma bonding on victims/survivors and how it can affect choices they make.	Victims/survivors can be triggered and/or retraumatized during routine healthcare visits.	The impact of chronic trauma on the brain and symptomology.	The importance of putting victim/survivor's wishes, safety, and well-being as a priority.	The scope and impact of trauma, including Adverse Childhood Experiences (ACES').
49	Nor	07/23/2021	Resident	PGY-1	1	1	1	5	3	5	5	5	5	5	5	5
50	Nor	07/23/2021	Other		2	3	3	3	3	4	4	5	5	5	5	5
51	Nor	07/23/2021	Other		3	4	5	3	5	5	5	5	5	5	5	5
52	Nor	07/23/2021	Resident		2	2	2	2	2	2	3	3	3	3	3	3
53	Nor	07/23/2021	Resident		4	3	2		4	2	5	4	4	5	5	5
54	Nor	07/23/2021	Resident	PGY-1	3	3	2	4	5	4	4	4	4	4	5	4
60	Sac	08/25/2021	Resident	PGY-1	3	3	4	3	5	3	5	4	5	4	5	5
61	Sac	08/25/2021	Resident	PGY-1	4	4	3	2	4	4	4	4	4	4	5	5
62	Sac	08/25/2021	Other		2	3	3	3	3	4	5	5	5	4	5	5
63	Sac	08/25/2021	Resident	PGY-2	4	4	4	4	4	4	4	4	4	4	4	4
64	Sac	08/25/2021	Resident	PGY-1	2	2	2	2	5	3	4	3	4	3	5	3
65	Sac	08/25/2021	Resident	PGY-1	4	5	4	4	5	5	5	5	4	4	5	5
66	Sac	08/25/2021	Resident	PGY-2	2	2	2	2	2	2	4	4	4	4	4	4
67	Sac	08/25/2021	Resident	PGY-1	3	4	4	3	5	3	5	5	5	5	5	5
68	Sac	08/25/2021	Resident	PGY-1	4	4	4	4	4	4	5	5	5	5	5	4
69	Red	08/12/2021	Resident	PGY-1	2	3	3	2	4	4	4	5	4	4	5	5
70	Red	08/12/2021			4	4	4	4	4	4	5	5	5	5	5	5
71	Red	08/12/2021	Resident	PGY-1	3	4	5	5	5	4	4	5	5	5	5	4
72	Red	08/12/2021	Resident	PGY-2	3	5	3	5	4	5	4	5	5	5	5	5
73	Red	08/12/2021	Resident	PGY-1	1	1	1	2	2	2	3	3	3	3	3	3

TIC Resident Training data, Part II

ID	Training Location:	Training Date:	What best describes you?	Which year?	BEFORE TRAINING				NOW			
					Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	I am comfortable with my understanding of trauma informed care.	I understand why trauma informed care is important when working with trafficked victim/survivors.	Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	I am comfortable with my understanding of trauma informed care.	I understand why trauma informed care is important when working with trafficked victim/survivors.
4	Sac	08/26/2020	Resident	PGY-2	3	3	2	4	5	5	4	5
6	Sac	12/09/2020	Resident	PGY-3	5	5	4	5	5	5	4	5
7	Sac	12/09/2020	Resident	PGY-3	5	5	5	5	5	5	5	5
8	Sac	08/26/2020	Resident	PGY-2	5	3	3	4	5	4	4	5
9	Sac	08/26/2020	Resident	PGY-1	5	4	4	5	5	4	4	5
10	Sac	08/26/2020	Resident	PGY-1	3	3	2	3	5	4	4	4
11	Sac	08/26/2020	Resident	PGY-1	4	4	3	4	5	4	3	4
12	Sac	08/26/2020	Resident	PGY-1	5	3	2	5	5	5	5	5
13	Sac	08/26/2020	Other		4	4	4	4	5	5	5	5
14	Sac	08/26/2020	Other		4	3	3	4	4	4	4	5
15	Sac	08/26/2020	Resident	PGY-1	5	3	3	5	5	4	4	5
16	Sac	08/26/2020	Resident	PGY-1	5	4	4	4	5	4	4	5
17	Sac	08/26/2020	Resident	PGY-1	5	3	3	5	5	5	5	5
18	Nor	03/09/2021	Resident	PGY-2	4	4	4	4	5	5	5	5
19	Nor	03/09/2021	Resident	PGY-1	4	3	2	4	4	3	3	4
21	Nor	03/09/2021	Resident	PGY-3	4	3	4	4	4	4	4	5
22	Nor	03/09/2021	Resident	PGY-3	4	3	3	4	5	4	4	4
23	Red	03/10/2021	Resident	PGY-2	4	4	4	4	4	4	4	4
24	Red	03/10/2021	Other		4	4	4	4	4	4		4
25	Red	03/10/2021	Resident	PGY-1	4	4	3	4	4	4	4	4
26	Red	03/10/2021	Resident	PGY-2	5	4	4	5	5	4	4	5
27	Red	03/10/2021	Resident	PGY-3	5	4	4	5	5	4	4	5
28	Nor	03/09/2021	Resident	PGY-1	5	3	3	5	5	4	4	5
29	Nor	03/09/2021	Resident	PGY-1	5	3	3	5	5	4	3	5
32	Nor	03/09/2021	Other		4	4	5	5	5	4	5	5
33	Nor	03/09/2021	Resident	PGY-1	5	4	4	4	5	4	4	5
38	Nor	03/09/2021	Resident	PGY-3	5	5	5	5	5	5	5	5
39	Red	03/10/2021	Resident	PGY-3	5	4	4	4	5	4	4	5
41	Nor	03/09/2021	Other		5	4	4	5	5		4	5
42	Red	03/10/2021	Resident	PGY-3	4	3	3	4	5	4	4	5
43	Red	03/10/2021	Resident	PGY-1	4	4	4	5	4	5	4	5
44	Red	03/10/2021	Resident	PGY-1	5	3	3	4	5	4	4	5
46	Nor	07/23/2021	Resident		4	3	3	4	4	4	4	4
47	Nor	07/23/2021	Resident	PGY-1	5	4	4	5	5	5	5	5
48	Nor	07/23/2021	Resident	PGY-1								
49	Nor	07/23/2021	Resident	PGY-1	4	4	2	4	5	5	5	5
50	Nor	07/23/2021	Other		5	4	4	4	5	4	4	4
51	Nor	07/23/2021	Other		5	4	4	5	5	5	5	5
52	Nor	07/23/2021	Resident									
53	Nor	07/23/2021	Resident		4	4	2	4	5	4	5	5

Attachment G

ID	Training Location:	Training Date:	What best describes you?	Which year?	BEFORE TRAINING				NOW			
					Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	I am comfortable with my understanding of trauma informed care.	I understand why trauma informed care is important when working with trafficked victim/survivors.	Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	I am comfortable with my understanding of trauma informed care.	I understand why trauma informed care is important when working with trafficked victim/survivors.
54	Nor	07/23/2021	Resident	PGY-1	5	3	3	4	5	4	4	5
60	Sac	08/25/2021	Resident	PGY-1	4	3	3	4	5	4	5	5
61	Sac	08/25/2021	Resident	PGY-1	5	3	2	4	5	4	2	5
62	Sac	08/25/2021	Other		4	3	4	4	5	5	5	5
63	Sac	08/25/2021	Resident	PGY-2	5	4	4		5	4	4	4
64	Sac	08/25/2021	Resident	PGY-1	5	3	2	5	5	3	2	5
65	Sac	08/25/2021	Resident	PGY-1	5	3	4	5	5	3	4	5
66	Sac	08/25/2021	Resident	PGY-2	4	4	4	4	4	4	4	4
67	Sac	08/25/2021	Resident	PGY-1	5	4	5	5	5	5	5	5
68	Sac	08/25/2021	Resident	PGY-1	4	3	3	4	5	4	4	5
69	Red	08/12/2021	Resident	PGY-1	4	3	2	4		4	4	5
70	Red	08/12/2021			4	4	4	4	5	5	5	5
71	Red	08/12/2021	Resident	PGY-1	5	4	4	5	5	4	5	5
72	Red	08/12/2021	Resident	PGY-2	5	4	3	5	5	4	4	5
73	Red	08/12/2021	Resident	PGY-1	3	2	2	2	4	3	3	3

TIC Resident Training data, Part III

ID	Training Location:	Training Date:	What best describes you?	Which year?	I would recommend this training to other resident physicians.	I learned new information from this training.	The trainer was knowledgeable on the subject manner.
4	Sac	08/26/2020	Resident	PGY-2	5	4	5
6	Sac	12/09/2020	Resident	PGY-3	5	5	5
7	Sac	12/09/2020	Resident	PGY-3	5	4	5
8	Sac	08/26/2020	Resident	PGY-2	5	5	5
9	Sac	08/26/2020	Resident	PGY-1	5	5	5
10	Sac	08/26/2020	Resident	PGY-1	5	4	5
11	Sac	08/26/2020	Resident	PGY-1	5	3	5
12	Sac	08/26/2020	Resident	PGY-1	5	5	5
13	Sac	08/26/2020	Other		4	5	5
14	Sac	08/26/2020	Other		5	5	5
15	Sac	08/26/2020	Resident	PGY-1	5	5	5
16	Sac	08/26/2020	Resident	PGY-1	4	5	5
17	Sac	08/26/2020	Resident	PGY-1	5	5	5
18	Nor	03/09/2021	Resident	PGY-2	4	4	4
19	Nor	03/09/2021	Resident	PGY-1	4	4	5
21	Nor	03/09/2021	Resident	PGY-3	4	4	4
22	Nor	03/09/2021	Resident	PGY-3	4	4	4
23	Red	03/10/2021	Resident	PGY-2	4	4	4
24	Red	03/10/2021	Other		4	4	5
25	Red	03/10/2021	Resident	PGY-1	4	4	5
26	Red	03/10/2021	Resident	PGY-2	5	5	5
27	Red	03/10/2021	Resident	PGY-3	5	4	5
28	Nor	03/09/2021	Resident	PGY-1	4	4	4
29	Nor	03/09/2021	Resident	PGY-1	5	5	5
32	Nor	03/09/2021	Other		5	4	5
33	Nor	03/09/2021	Resident	PGY-1	4	4	4
38	Nor	03/09/2021	Resident	PGY-3	5	5	5
39	Red	03/10/2021	Resident	PGY-3	5	4	5
41	Nor	03/09/2021	Other		5	4	5
42	Red	03/10/2021	Resident	PGY-3	4	4	4
43	Red	03/10/2021	Resident	PGY-1	5	5	5
44	Red	03/10/2021	Resident	PGY-1	5	5	5
46	Nor	07/23/2021	Resident		4	4	4
47	Nor	07/23/2021	Resident	PGY-1	4	4	5
48	Nor	07/23/2021	Resident	PGY-1			
49	Nor	07/23/2021	Resident	PGY-1	4	4	5
50	Nor	07/23/2021	Other		5	5	5
51	Nor	07/23/2021	Other		5	5	5
52	Nor	07/23/2021	Resident				
53	Nor	07/23/2021	Resident		5	5	5
54	Nor	07/23/2021	Resident	PGY-1	5	5	5
60	Sac	08/25/2021	Resident	PGY-1	5	5	5
61	Sac	08/25/2021	Resident	PGY-1	5	5	5
62	Sac	08/25/2021	Other		5	5	5
63	Sac	08/25/2021	Resident	PGY-2	5	3	5
64	Sac	08/25/2021	Resident	PGY-1	5	5	5
65	Sac	08/25/2021	Resident	PGY-1	5	5	5

ID	Training Location:	Training Date:	What best describes you?	Which year?	I would recommend this training to other resident physicians.	I learned new information from this training.	The trainer was knowledgeable on the subject manner.
66	Sac	08/25/2021	Resident	PGY-2	4	5	4
67	Sac	08/25/2021	Resident	PGY-1	5	5	5
68	Sac	08/25/2021	Resident	PGY-1	4	4	4
69	Red	08/12/2021	Resident	PGY-1	5	5	5
70	Red	08/12/2021			5	5	5
71	Red	08/12/2021	Resident	PGY-1	5	5	5
72	Red	08/12/2021	Resident	PGY-2	5	5	5
73	Red	08/12/2021	Resident	PGY-1	4	4	5

PPE Resident Training data, Part I

ID	Training Location:	Training Date:	What best describes you?	Which year?	BEFORE TRAINING						NOW					
					The long-term impacts of trauma bonding on victims/survivors and how it can affect choices they make.	Victims/survivors can be triggered and/or retraumatized during routine healthcare visits.	The impact of chronic trauma on the brain and symptomology.	Mandated reporting requirements/responsibility of a physician for an identified trafficking victim who is under 18 years old compared to a victim 18 or older.	The physical indicators of a trafficked victim/survivor.	An understanding of the role of the patient advocate in the MSH.	The long-term impacts of trauma bonding on victims/survivors and how it can affect choices they make.	Victims/survivors can be triggered and/or retraumatized during routine healthcare visits.	The impact of chronic trauma on the brain and symptomology.	Mandated reporting requirements/responsibility of a physician for an identified trafficking victim who is under 18 years old compared to a victim 18 or older.	The physical indicators of a trafficked victim/survivor.	An understanding of the role of the patient advocate in the MSH.
2	Nor	09/23/2020	Resident	PGY-1	4	5	5	2	3	1	5	5	5	3	4	3
3	Nor	09/23/2020	Resident	PGY-1	5	5	5	5	1	5	5	5	5	3	3	5
4	Nor	09/23/2020	Resident	PGY-2	5	5	2	4	3	1	5	5	3	4	4	3
5	Nor	09/23/2020	Resident	PGY-2	1	4	4	2	1	1	3	5	5	3	2	3
6	Nor	09/23/2020	Resident	PGY-2	3	3	2	2	2	3	5	5	5	3	4	4
7	Nor	09/23/2020	Resident	PGY-2	3	4	4	2	4	4	4	4	4	4	4	4
8	Nor	09/23/2020	Resident	PGY-3	1	2	2	2	1	1	5	5	5	5	4	5
9	Nor	09/23/2020	Resident	PGY-3		4	3	4	4	4	4	4	3	4	4	4
10	Nor	09/23/2020	Resident	PGY-3	4	5	4	4	3	3	5	5	5	5	4	5
11	Nor	09/23/2020	Resident	PGY-3	3	4	4	4	3	4	5	5	5	5	5	5
12	Nor	09/23/2020	Resident	PGY-3	3	4	3	3	4	3	4	4	5	4	4	4
13	Nor	09/23/2020			3	4	4	4	3	3	5	5	4	5	5	4
14	Nor	09/23/2020	Resident	PGY-3	2	3	3	2	3	3	4	4	4	4	4	4
17	Sac	11/18/2020	Resident	PGY-3	5	5	5	5	5	5	5	5	5	5	5	5
19	Sac	11/18/2020	Resident	PGY-1	3	3	4	3	4	3	4	4	4	4	4	4
20	Sac	11/18/2020	Resident	PGY-1	3	4	3	4	4	3	4	5	4	5	4	4
21	Sac	11/18/2020	Other		3	4	3	1	2	2	4	5	4	3	3	4
22	Sac	11/18/2020	Resident	PGY-2	4	4	4	4	3	4	4	4	4	4	4	4
23	Sac	11/18/2020	Other		5	5	5	5	5	5	5	5	5	5	5	5
24	Sac	11/18/2020	Other		1	1	1	1	1	1	5	5	5	5	5	5
25	Sac	11/18/2020	Resident	PGY-3	4	4	4	3	4	4	4	5	4	4	4	5
26	Sac	11/18/2020	Resident	PGY-1	3	3	3	3	3	3	4	4	4	4	4	4
27	Sac	11/18/2020	Resident	PGY-2	3	4	3	2	4	3	4	5	3	4	4	5
28	Red	03/15/2021	Resident	PGY-2	4	5	5	4	5	5	5	5	5	4	5	5
29	Red	03/15/2021	Resident	PGY-3	3	3	3	2	3	2	4	4	5	3	3	5
30	Red	03/15/2021	Resident	PGY-1	1	2	1	5	2	1	5		4	5		4
35	Red	03/15/2021	Resident	PGY-1	2	2	2	5	3	2	4	3	3	5	4	5
37	Nor	09/15/2021	Resident	PGY-2	5	5	5	5	3	3	5	5	5	5	4	5
38	Nor	09/15/2021	Resident	PGY-2	4	4	4	4	4	3	5	5	5	5	5	4
39	Nor	09/15/2021	Resident	PGY-2	4	4	4	4	4	4	5	5	5	5	5	5
41	Nor	09/15/2021	Resident		4	4	4	4	4	2	5	5	5	5	4	5
42	Nor	09/15/2021	Resident	PGY-3	4	4	4	5	4	5	5	5	5	5	4	5
43	Nor	09/15/2021	Resident	PGY-3	5	5	5	5	5	5	5	5	5	5	5	5
44	Nor	09/15/2021	Resident	PGY-1	2	3	2	2	2	3	4	5	4	4	3	4
45	Nor	09/15/2021	Resident		3	4	4	4	4	4	4	4	4	4	4	4
46	Nor	09/15/2021	Resident	PGY-3	4	3	2	4	3	1	4	4	3	4	4	3

Attachment G

ID	Training Location:	Training Date:	What best describes you?	Which year?	BEFORE TRAINING						NOW					
					The long-term impacts of trauma bonding on victims/survivors and how it can affect choices they make.	Victims/survivors can be triggered and/or retraumatized during routine healthcare visits.	The impact of chronic trauma on the brain and symptomology.	Mandated reporting requirements/responsibility of a physician for an identified trafficking victim who is under 18 years old compared to a victim 18 or older.	The physical indicators of a trafficked victim/survivor.	An understanding of the role of the patient advocate in the MSH.	The long-term impacts of trauma bonding on victims/survivors and how it can affect choices they make.	Victims/survivors can be triggered and/or retraumatized during routine healthcare visits.	The impact of chronic trauma on the brain and symptomology.	Mandated reporting requirements/responsibility of a physician for an identified trafficking victim who is under 18 years old compared to a victim 18 or older.	The physical indicators of a trafficked victim/survivor.	An understanding of the role of the patient advocate in the MSH.
47	Nor	09/15/2021	Resident	PGY-1	3	3	3	3	3	3	4	4	4	4	4	4
48	Nor	09/15/2021	Resident	PGY-1	3	4	5	4	3	3	5	5	5	5	5	5
49	Nor	09/15/2021	Resident	PGY-3	3	4	3	3	3	3	4	4	4	4	4	4
50	Nor	09/15/2021	Resident	PGY-1	5	5	5	5	5	5	5	5	5	5	5	5
51	Nor	09/15/2021	Resident	PGY-3	3	3	3	3	3	3	4	4	4	4	4	4
52	Nor	09/15/2021	Resident	PGY-3	3	4	4	4	3	4	4	4	4	4	4	4
53	Nor	09/15/2021	Resident	PGY-2	4	3	2	2	3	3	4	4	3	2	4	4
54	Nor	09/15/2021	Resident	PGY-2	4	5	4	3	3	3	4	5	5	4	3	4
55	Nor	09/15/2021	Resident	PGY-1	4	4	5	5	5	4	5	5	5	5	5	5

PPE Resident Training data, Part II

ID	Training Location:	Training Date:	What best describes you?	Which year?	BEFORE TRAINING				NOW			
					I am comfortable with my understandin g of human trafficking victims, both labor and sex.	I am confident that I can raise the question of human trafficking with victims/survivors.	I believe it is essential to empower adult human trafficking victims to make their own healthcare choices, and support their wishes, safety and concerns.	I understanding the importance and reasons for the "crucial points" to patient visits.	I am comfortable with my understanding of human trafficking victims, both labor and sex.	I am confident that I can raise the question of human trafficking with victims/survivors.	I believe it is essential to empower adult human trafficking victims to make their own healthcare choices, and support their wishes, safety and concerns.	I understanding the importance and reasons for the "crucial points" to patient visits.
2	Nor	09/23/2020	Resident	PGY-1	3	4	5	4	4	5	5	5
3	Nor	09/23/2020	Resident	PGY-1	1	1	5	5	4	4	5	5
4	Nor	09/23/2020	Resident	PGY-2								
5	Nor	09/23/2020	Resident	PGY-2	2	3	4	3	3	4	5	4
6	Nor	09/23/2020	Resident	PGY-2	3	3	3	2	4	4	5	4
7	Nor	09/23/2020	Resident	PGY-2	3	2	4	4	4	4	4	4
8	Nor	09/23/2020	Resident	PGY-3	1	1	5	2	4	3	5	5
9	Nor	09/23/2020	Resident	PGY-3	4		5	3	4		5	3
10	Nor	09/23/2020	Resident	PGY-3	3	3	4	3	4	3	5	4
11	Nor	09/23/2020	Resident	PGY-3	4	4	4	4	5	5	5	5
12	Nor	09/23/2020	Resident	PGY-3	4	4	5	4	4	5	5	5
13	Nor	09/23/2020			2	4	4	4	4	5	5	5
14	Nor	09/23/2020	Resident	PGY-3	4	3	3	2	4	4	4	4
17	Sac	11/18/2020	Resident	PGY-3	5	5	5	5	5	5	5	5
19	Sac	11/18/2020	Resident	PGY-1	4	2	5	4	4	4	5	4
20	Sac	11/18/2020	Resident	PGY-1	2	3	4	2	3	4	4	3
21	Sac	11/18/2020	Other		2	4	5	3	4	4	5	4
22	Sac	11/18/2020	Resident	PGY-2	3	4	4	3	4	4	4	3
23	Sac	11/18/2020	Other		5	5	5	5	5	5	5	5
24	Sac	11/18/2020	Other		1	1	1	1	5	5	5	5
25	Sac	11/18/2020	Resident	PGY-3	4	4	4	3	4	4	4	3
26	Sac	11/18/2020	Resident	PGY-1	2	3	5	3	3	4	5	4
27	Sac	11/18/2020	Resident	PGY-2	4	4	5	3	4	5	5	4
28	Red	03/15/2021	Resident	PGY-2	4	4	5	3	4	4	5	3
29	Red	03/15/2021	Resident	PGY-3	4	3	5	4	5	4	5	4
30	Red	03/15/2021	Resident	PGY-1	3	2	5	3	4	5	5	4
35	Red	03/15/2021	Resident	PGY-1	2	2	4	3	5	5	5	5
37	Nor	09/15/2021	Resident	PGY-2	3	3	5	4	4	5	5	5
38	Nor	09/15/2021	Resident	PGY-2	4	2	5	5	5	4	5	5
39	Nor	09/15/2021	Resident	PGY-2	2	3	3	2	4	4	5	5
41	Nor	09/15/2021	Resident		2	2	4	2	3	4	5	2
42	Nor	09/15/2021	Resident	PGY-3	4	4	5	3	5	5	5	4
43	Nor	09/15/2021	Resident	PGY-3	4	3	5	5	4	4	5	5
44	Nor	09/15/2021	Resident	PGY-1	2	2	5	3	4	5	5	4
45	Nor	09/15/2021	Resident		4	3	5	3	4	4	5	4
46	Nor	09/15/2021	Resident	PGY-3	2	3	5	3	3	5	5	3
47	Nor	09/15/2021	Resident	PGY-1	3	3	3	3	4	4	4	4

Attachment G

					BEFORE TRAINING				NOW			
ID	Training Location:	Training Date:	What best describes you?	Which year?	I am comfortable with my understandin g of human trafficking victims, both labor and sex.	I am confident that I can raise the question of human trafficking with victims/survivors.	I believe it is essential to empower adult human trafficking victims to make their own healthcare choices, and support their wishes, safety and concerns.	I understanding the importance and reasons for the "crucial points" to patient visits.	I am comfortable with my understanding of human trafficking victims, both labor and sex.	I am confident that I can raise the question of human trafficking with victims/survivors.	I believe it is essential to empower adult human trafficking victims to make their own healthcare choices, and support their wishes, safety and concerns.	I understanding the importance and reasons for the "crucial points" to patient visits.
48	Nor	09/15/2021	Resident	PGY-1	4	3	4	3	5	5	5	5
49	Nor	09/15/2021	Resident	PGY-3	4	4	4	4	5	5	5	5
50	Nor	09/15/2021	Resident	PGY-1	5	4	5	5	5	4	5	5
51	Nor	09/15/2021	Resident	PGY-3	3	3	3	3	4	4	4	4
52	Nor	09/15/2021	Resident	PGY-3	4	4	5	5	4	4	5	5
53	Nor	09/15/2021	Resident	PGY-2	3	2	4	3	4	4	4	3
54	Nor	09/15/2021	Resident	PGY-2	3	3	5	3	3	3	5	3
55	Nor	09/15/2021	Resident	PGY-1	5	4	5	4	5	4	5	5

Attachment G

PPE Resident Training data, Part III

ID	Training Location:	Training Date:	What best describes you?	Which year?	I would recommend this training to other resident physicians.	I learned new information from this training.	The trainer was knowledgeable on the subject manner.
2	Nor	09/23/2020	Resident	PGY-1	5	5	5
3	Nor	09/23/2020	Resident	PGY-1	5	5	5
4	Nor	09/23/2020	Resident	PGY-2			
5	Nor	09/23/2020	Resident	PGY-2	5	5	5
6	Nor	09/23/2020	Resident	PGY-2	5	5	5
7	Nor	09/23/2020	Resident	PGY-2	5	5	5
8	Nor	09/23/2020	Resident	PGY-3	5	5	5
9	Nor	09/23/2020	Resident	PGY-3	4	3	4
10	Nor	09/23/2020	Resident	PGY-3	5	5	5
11	Nor	09/23/2020	Resident	PGY-3	5	5	5
12	Nor	09/23/2020	Resident	PGY-3	5	4	5
13	Nor	09/23/2020			4	5	5
14	Nor	09/23/2020	Resident	PGY-3	5	5	5
17	Sac	11/18/2020	Resident	PGY-3	5	5	5
19	Sac	11/18/2020	Resident	PGY-1	5	5	5
20	Sac	11/18/2020	Resident	PGY-1	4	5	5
21	Sac	11/18/2020	Other		4	5	5
22	Sac	11/18/2020	Resident	PGY-2	5	5	5
23	Sac	11/18/2020	Other		5	5	5
24	Sac	11/18/2020	Other		5	5	5
25	Sac	11/18/2020	Resident	PGY-3	5	5	5
26	Sac	11/18/2020	Resident	PGY-1	5	5	5
27	Sac	11/18/2020	Resident	PGY-2	5	5	5
28	Red	03/15/2021	Resident	PGY-2	5	5	5
29	Red	03/15/2021	Resident	PGY-3	5	4	5
30	Red	03/15/2021	Resident	PGY-1	5	5	5
35	Red	03/15/2021	Resident	PGY-1	5	5	5
37	Nor	09/15/2021	Resident	PGY-2	5	5	5
38	Nor	09/15/2021	Resident	PGY-2	5	5	5
39	Nor	09/15/2021	Resident	PGY-2	4	5	5
41	Nor	09/15/2021	Resident		4	4	4
42	Nor	09/15/2021	Resident	PGY-3	5	5	5
43	Nor	09/15/2021	Resident	PGY-3	4	4	5
44	Nor	09/15/2021	Resident	PGY-1	5	5	5
45	Nor	09/15/2021	Resident		5	5	5
46	Nor	09/15/2021	Resident	PGY-3	5	5	5
47	Nor	09/15/2021	Resident	PGY-1	4	4	4
48	Nor	09/15/2021	Resident	PGY-1	5	5	5
49	Nor	09/15/2021	Resident	PGY-3	4	4	4
50	Nor	09/15/2021	Resident	PGY-1	4	4	5
51	Nor	09/15/2021	Resident	PGY-3	4	4	4
52	Nor	09/15/2021	Resident	PGY-3	5	5	5
53	Nor	09/15/2021	Resident	PGY-2	4	4	5
54	Nor	09/15/2021	Resident	PGY-2	4	4	5
55	Nor	09/15/2021	Resident	PGY-1	4	4	5

3rd Year Resident Survey

ID	Location:	What year did you complete your residency?	# of trafficked victims worked with at MSH?	Length of time at MSH?	BEFORE TRAINING				NOW				Did your experience at the Medical Safe Haven clinic prepare you to care for the medical needs of trafficked victims and survivors using a victim centered approach?
					Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	If I identify a human trafficking victim I know where to find community and national resources for the victim.	I believe it is essential to empower adult human trafficking victims to make their own choices regarding their trafficking situation.	Human Trafficking education is an important component of resident physician training.	I am confident that I will be able to recognize common indicators, signs, and symptoms of abuse, neglect or violence, including human trafficking.	If I identify a human trafficking victim I know where to find community and national resources for the victim.	I believe it is essential to empower adult human trafficking victims to make their own choices regarding their trafficking situation.	
2	Sac	2020	15	3 yrs	2	2	2	3	4	4	4	4	Yes
3	Sac	2020	20	2 yrs	2	1	1	2	4	4	3	4	Yes
4	Nor	2020	0	1 yr	1	1	1	1	2	2	2	2	No
5	Nor	2020	0	1 yr	1	1	1	1	2	1	2	1	Yes
8	Sac	2020	20	3 yrs	2	2	2	2	4	4	4	4	Yes
9	Red	2020	0		1	1	1	1	1	1	1	1	
10	Nor	2020	0	1 yr	2	2	2	2	4	4	4	4	Yes
11	Sac	2020	35	3 yrs	1	1	1	1	4	4	4	4	Yes
13	Sac	2020	20	3 yrs	2	2	2	2	4	4	4	4	Yes
14	Nor	2020	0	1 yr	1	1	1	1	3	3	2	2	Yes
15	Nor	2020	0	1 yr	2	2	1	2	3	3	2	3	Yes
17	Sac	2020	10	3 yrs	2	3	2	4	4	4	4	4	Yes
18	Sac	2020	15	3 yrs	2	2	2	1	4	4	4	4	Yes
21	Sac	2018	15	2 yrs	1	1	1	1	3	4	4	4	Yes
22	Sac	2018	2	2 yrs	3	3	3	3	3	3	3	3	Yes
23	Sac	2020	30	3 yrs	2	1	2	2	4	3	3	4	Yes
24	Sac	2019	10	2 yrs	1	1	1	1	4	4	3	3	Yes
28	Sac	2021	40	3 yrs	3	3	2	2	4	4	4	4	Yes
29	Sac	2021	30	3 yrs	1	1	1	1	3	3	3	3	Yes
31	Sac	2021	20	2 yrs	1	1	1	1	3	3	3	3	Yes
32	Sac	2021	35	3 yrs	2	2	2	2	3	3	4	4	Yes
34	Sac	2021	25	3 yrs	2	3	2	2	3	4	4	4	Yes
35	Nor	2021	4	1 yr	2	2	2	2	3	3	3	4	Yes
36	Red	2021	1	1 yr	2	2	2	1	2	2	2	1	No
37	Red	2021	2	2 yrs	3	3	3	3	3	3	3	3	Yes
38	Red	2021	2	2 yrs	3	3	4	1	4	4	3	3	Yes
39	Red	2021	2	2 yrs	2	2	2	3	3	4	4	4	Yes
40	Red	2021	1	2 yrs	2	3	3	3	3	3	3	3	Yes
41	Sac	2021	15	2 yrs	2	2	2	2	4	4	4	4	Yes
42	Nor	2021	10	1 yr	3	3	3	3	4	4	4	4	Yes

ID	How have experience(s) at the Medical Safe Haven clinic prepared you to care for the medical needs of trafficked victims and survivors using a victim centered approach?	In what ways did your experience at the Medical Safe Haven clinic not prepare you to care for the medical needs of trafficked victims and survivors using a victim centered approach?	What additional trainings/experiences would have helped you when working with trafficking victims/survivors?	Lastly, take a moment to think about your future as a physician. How do you plan to take your experiences with the Medical Safe Haven clinic with you? How do you envision using these experiences?
2	Having dedicated time to spend with patients, formal didactic time and mentor ship was incredibly helpful.			I plan to use these trauma informed methods to care for patients from a variety of backgrounds with a history of trauma. I also feel more prepared to identify trafficking victims.
3	Our initial training improves our ability to identify victims and safe ways to approach provision of resources and care to these patients in a non-threatening, patient-centered way. The structure of our clinic allows for us to get these patients folded in for MSH intake appointments if we identify them . Most often, they come to our clinic through community resource partners like Weave. Scheduled visits with these patients are primarily structured to enable the patient doing the talking and the provider doing the listening and because intakes are given and entire hour, patients are usually able to start opening up about their experiences. This is key to building trust. Constant contact within our outpatient clinic with our MSH patients from the time of their intake onwards regardless of their medical needs is key to continuing trust-building and key to normalizing medical visits for these patients who formerly feared medical attention due to it's connotation with punitive measures.		Working at GHC with trans patients (many of whom are or were engaged in survival sex work). Listening to lectures provided by community leaders and organizers such as those who work at Weave.	I plan to initiate trainings in trauma-informed, victim-centered care for all staff and practictioners in future clinics in which I work. I also plan to involve community organizations and form relationships similar to the relationships our clinic has with Weave.
4		Haven't started to see any patients, I do not know	Actually seeing patients	Not sure, did not get any patients
5			videos or practice encounters	
8				
9				
10	The lectures were very comprehensive and not isolated events. The team came back on several other occassions to go into more depth with real life cases. It really opened my mind.		We just started our training but I am confident that the underclassmen that will start with real patients will have a very rewarding experience, be exposed to a different world with a silenced population that will be able to be heard and understood by their physicians. I look forward to seeing Northridge Family Medicine Residency gain this experience and become leaders in the community.	I plan to take the key point of it being a "victim-centered approach," to guide my care. I think we can be very effective as physicians in providing a safe place for these victims to obtain care
11	It has made the most impact on my medical career. I think all residents should undergo this training and learn to care for these patients.		We had tons but maybe more resiliency training.	These experiences have been instrumental in developing my approach to patient care. I plan to start a medical safe haven in my future practice and to teach the other physicians to care for these patients there. I discussed this with them prior to joining.
13	I am more comfortable with initiating conversations and questions about trafficking and I am familiar with the different community resources available to help these victims.		Spending more time with the community organizations (possibly two days rather than one half day) so we could learn more about their services.	I plan to be more vigilant and screen patients as necessary when I am concerned about them being victims. I would like to provide a safe environment for them to obtain the care that they need a deserve.

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14	I have learned some approaches in ide tidying and approaching these patients from the info sessions we have had , however, we never actually started seeing patients yet		Actual patient encounters	I am happy that I will be more informed with the terminology. I will be more aware in ide tidying and more sensitive and I formed in my approach to these patients. I had an encounter with one patient in the hospital at the beginning of our training and was glad I had more sessions to ask questions in regards to that encounter but I wish i had more patient interactions to learn from
15	Yes, added tools and practicing conversations helped with my confidence		Real life patients coming into training sessions may add value	Keep the idea of trauma informed care when dealing with future patients and hopefully help this population in the future
17	Identifying ways to connect with patients of this population		none	Identifying victims. Patient centered trauma informed approach with all patients.
18	I have learned how to provide trauma informed, victim centered care. I feel that my experience working with survivors has given me confidence to both work towards identifying victims and assist victims in their path to recovery.		I feel that I received adequate training and experience.	I hope to replicate the dignity health approach/ model h to identifying and treating victims at the future hospitals I work at. I have started to use trauma informed care in many of my encounters, even those that are not directly related to human trafficking victims.
21	Gave me a framework to think about encounters with medical professionals (esp from the perspective of a chronically traumatized patient). Allowed me to loosen the structure for interview, understanding that there was no way to "get" the patient to tell me a straight story and that trying to do so wasn't helpful for either of us. Gave me permission to not always get "all the data" if it came at the expense of making a patient feel like they weren't in control of the encounter and if they didn't feel safe because of it.		More hands-on, real-time experience with patient, just volume.	Trauma informed care is now a regular part of my practice, regardless of whether I'm working with trafficking victims/survivors or not. I pay attention to non-verbal communication more critically and inquire about those kinds of things on a regular basis to figure out if it is just an "odd behavior" or more of a red flag. If I'm ever in a practice setting where trauma-informed care is not practiced, I'd advocate for training for all staff (not just physicians).
22			Seeing true victims would be helpful. Unfortunately all the patients I saw seemed to be seeking after alternate benefits including immigration paperwork, financial and materialistic gain.	I will be more prepared and aware of their situation and be able to direct them to the appropriate resources.
23				
24	I have a greater awareness of both trauma informed care in addition to signs of human trafficking.		na	I have used these skills a few times my current urgent care with identification of possible trafficking patients as well as patients with significant trauma history.
28	Working with the patients in MSH clinic and the workshops led by the MSH team. Also, speaking with the patient advocates and working with them has helped me learn a lot about providing patient-centered trauma informed care.		I cannot think of any additional trainings at this time.	I hope to use them in almost all my encounters.
29	Have learned the unique challenges faced by these victimized patients and techniques that are helpful and applicable to their unique situation.		I cannot think of any; from MSH clinic to the tours of the various programs (CASH, WEAVE, City of Refuge) I feel this program prepared me wonderfully.	I plan to incorporate trauma-informed care and patient-centered care into my practice daily. I also plan to care for patients that are victims of trafficking and will be extensively using the skills I learned during residency.
31	Shared decision making, open discussion, sensitivity		Unsure	Noticing red flags, offering resources
32	Provided me with tools and skills needed to support and provide appropriate care for special vulnerable population.		More msh clinic	Applying the skills I've acquired to other vulnerable populations
34				
35	I have learned how to best approach sensitive issues and make people feel more comfortable sharing. I have learned		It would have helped to have more experience	I envision being able to more readily able to identify trafficking victims when in the past I would have not noticed. I will take

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	to accept whatever the person is sharing in a nonjudgmental way.			my newly learned communication skills and adopt this into taking care of all of my patients.
36		I only had 1 encounter with 1 patient so it's not a good indicator of what the MSH can offer.	Having more patients who are trafficking victims/survivors.	Be more aware of who could potentially be victims.
37	I did not deliver many skills at MFHC due to not seeing enough patients despite expressing desire to do so.		Actually, seeing trafficked/victims	Always pay attention to the subtle little cues.
38	Taught me how to ask questions and also to make the victim and survivor feel more confident in their provider and building trust (physician-patient trust relationship). Also taught me a lot more about trauma-informed care, and what other nonverbal concerning clues to look for during clinic encounters.		Field experience	I would be more compassionate toward patients of trafficked victims. Also be very vast with resources available for these patients anywhere I am going to be practicing! Build trust by having frequent visits to build good rapport.
39			Working with the District Attorney's office to have some insight into the legal issues these patients deal with.	
40	Improved identification of warning signs		More patients seen	Remain aware of trauma and its effects on patients in any setting
41	Being exposed to what human trafficking actually is and how prevalent it is in our community was the most eye opening. Hearing the experience of victims our clinic has helped and how we as providers can support them is what helped the most.		the mock interview Dr. Chaffin did with a real patient	Prior to MSH I had no idea that trafficking was such a problem and so prevalent in California. I can now recognize possible victims and am comfortable starting that conversation with them.
42	Yes it has. The training sessions were very informative and having our patient advocate Elivira during the visits has been very helpful.		Continue yearly training sessions as refreshers	I am planning to continue working with Med Safe Haven clinic at my future fellowship and job.

Partner Survey Responses

ID	Medical Safe Haven staff communicate regularly with staff at my agency.	Medical Safe Haven staff respond quickly to inquiries about their services.	Medical Safe Haven staff respond quickly to our victim/survivor referrals to the clinic.	Medical Safe Haven staff respond timely to secure appointments for victim/survivors that we serve.	Medical Safe Haven staff are well informed about the needs and challenges of trafficked victims/survivors.	During the pandemic…			My agency collaborates with the Medical Safe Haven staff to communicate about victims/survivors in which we are both serving.	My agency regularly communicates with Safe Haven staff to keep them informed about ways in which we can support victims/survivors.
						Were you able to communicate with Medical Safe Haven staff when needed?: :During the pandemic...	Were your clients able to receive care from the Medical Safe Haven clinic?	Did the Medical Safe Haven clinic provide safe and innovative approaches to healthcare for your clients, such as telehealth appointments?		
1	4	5	4	4	4	3	3	3	4	4
2	5	5	5	5	5	3	3	3	5	5
3	4	4	4	4	5	3	2	4	5	4
4	5	5	5	5	5	4	4	4	5	5
5	4	4	4	4	5	3	4	4	4	5
6	4	3	3	4	5	2	3	3	4	4
7	5	5	5	5	5	4	4	4	5	5
8	5	5	5	5	5	4	4	4	5	5
9	5	4	4	4	4	3	3	3	4	3
10	5	5	5	5	5	4	4	4	5	5
11	2	5	5	5	5				3	1
How could this improve:	• By mutually referring to each others services and being in partnership where survivor needs are concerned. • The scheduled monthly check-ins have been a great asset!	• At the time when I needed services for a client, MSH was in transition with personnel so the response time was not good but understood the challenge. Normally response time is Excellent.	• For the most part yes, but we've run into a few hiccups in recent weeks while our main point of contact at MSH has been on vacation and medical leave. There wasn't much clarity on who we could contact instead, and there were some delays in connecting our client. Would be great if staff out of office had an automated e-mail away message with alternative contacts. • At the time when I needed services for a client, MSH was	• Response time has been great. We understand you are serving a large community. Sometimes we are given to appointment times as an option and when chosen, we've heard back that time is no longer available. Clients are still seen, we've just had to adjust schedules to the different time	•	• I didn't need to.	• That was more to do with not being able to be seen in person. • I didn't make any referrals during the pandemic.	•	•	• On occasions where I have referred clients to MSH I haven't received any communication after the referral, but I wouldn't really expect it due to client confidentiality. • There isn't really any mutual communication between our services outside of our/their attendance at the community coalition meeting against trafficking every few months. We all give general updates at that meeting but don't typically collaborate much in

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			in transition with personnel so the response time was not good but understood the challenge. Normally response time is Excellent. • There were some bumps in the road in-between WEAVE advocates.							between about survivor support.

What are some suggestions to improve your partnership with the Safe Haven Clinic?

- We are all working through the challenges of the pandemic, the clients volatileness and our own personnel challenges. I believe both agencies do the best they can considering the circumstances, but Safe Haven Clinic is a great partner.
- Some clients are often needing immediate appointments and most appointments are scheduled on Fridays or too far out. It would help if clients had the option to walk-in. In case clients are not seen in-person due to scheduling conflict, it would help if clinic considers providing telehealth consultation, while the client is scheduled for more thorough check-up. Clients have positive feedback on clinic staff, however, it is often the case that clinic to far from their home. Since it's a bit far our most of the times, it'd be great for clinic to consider collaborating with transportation services.
- We (both CASH and MSH) had previously stated that meetings would be useful and we have been attending them monthly now. We are on the right track!!! And we really appreciate this partnership.
- Start more programs all over the state, even in smaller rural places like ours.
- Nothing! I am glad we are now having our monthly check-ins, this has improved our ability to communicate with you all incredibly!
- We do not have any suggestions at this time, and continue to appreciate the partnership with the MSH. The staff arranges biweekly meetings where we are able to readily share updates, concerns, and strategize ways to address any problems that may occur, as well as plan outreach and educational efforts.
- If we received referrals from MSH we could work together closely to support the same clients with their general needs. Currently to date we have only received one or two referrals in the early stages of the role. We have referred to them where possible but are more limited in our ability to do so since many of our clients needs are already taken care of medically by the time we come in contact with them. I do think outsourcing clients to other services makes a lot of sense so the client has good wrap around care and a stronger support network.
- Provide alternative number to contact when someone is unavailable
- Some combined trainings that facilitates equity, diversity, and inclusion training to learn more how we can best support each other and survivors.