Implementation of the Short Screen for Child Sex Trafficking (SSCST)

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Author Note

This quality improvement initiative was completed with approval from the project site and the University of Maryland. Project Lead is a paid employee at the project site. There are no additional conflicts of interest to disclose.

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Abstract

Problem: In a tertiary, Level 1-designated trauma center pediatric emergency department, a random one-month review revealed only 1 of 134 patients (0.7%) were screened for Child Sex Trafficking (CST) using a validated screening tool. **Purpose:** Implementation of the Short Screen for Child Sex Trafficking (SSCST) aims to identify patients at high risk for CST to provide safe disposition planning for true victims of CST and community referrals for false-positive patients. **Methods:** Approximately 120 staff members, including medical providers, nurses, and social workers, were trained to use the SSCST screening tool. Medical providers stratified patients as “high-risk” or “low risk”, with high-risk patients undergoing further evaluation to confirm CST status. Upon initial implementation, multidisciplinary team members expressed the need for an additional validated tool to assess high-risk patients without relying on patient self-disclosure of CST. Thus, the protocol was amended to providing outpatient sexual health clinic referrals to all SSCST-eligible patients, regardless of risk stratification. This nursing-led intervention involved 60 nurses with a distribution goal of 50%. Data collection occurred over 15 weeks via surveys. **Results:** During the pre-implementation period, a weekly average of 23 eligible patients presented with a 0% resource distribution rate. After initial SSCST implementation in week 4, the referral distribution rate increased 20%. The amended protocol was implemented from week 5-15, during which an average of 35 eligible patients presented weekly with fluctuations in referral distribution rates between 0-10%, falling short of the 50% goal despite a 70% RN education review rate. **Conclusions:** Outcomes from the amended protocol demonstrate several systemic barriers to distribution consistent with current literature. Limited distribution rates were reported due to time constraints, prioritization of higher acuity patients, high patient volumes, discharges completed by Advanced Practice Providers, and

difficulty identifying eligible patients. No correlation was observed between referral rates, RN education completion, or volume of eligible patients. Without formal SSCST screening, referral demand increased as all eligible patients received referrals regardless of CST risk level. Future formal screening using the SSCST tool could better identify high-risk patients, enabling a more targeted resource distribution practice and patient outcomes.

Keywords: child sex trafficking, CST, Short Screen for Child Sex Trafficking, SSCST, pediatric, child abuse, pediatric abuse, pediatric screenings, pediatric sexual health care, outpatient referrals for sexual health care

Implementation of the Short Screen for Child Sex Trafficking (SSCST)

The National Center of Missing and Exploited Children (NCMEC) received more than 17,200 reports of child sex trafficking (CST) in 2021 with Maryland ranking as the eighth state with the highest call rates (2022). Baltimore City has the highest rate of identified CST victims in the state, estimating 1.92 case per 100,000 people, although true rates remain largely underreported (Department of Local Social Service, 2022). Baltimore City is a conducive area for patrons of child trafficking due to the ease of crossing state lines via the Amtrak station, Baltimore shipping seaport, and Baltimore-Washington International Airport (Human trafficking in Maryland, n.d.). Socioeconomic and educational disparities in Baltimore increase a victim's vulnerability, allowing for easy manipulation and recruitment through false promises of basic needs, safety, and support (NCMEC, 2022). Escape from the industry is difficult, as victims are threatened by physical and psychological abuse. This increases the risk of devastating consequences, such as infliction of traumatic injuries, mental health instability, drug use, and contraction of sexually transmitted diseases (STI) (Chon, 2021).

Studies estimate an average of 80% of trafficked minors interacted with a health care provider prior to discovery of their exploitation (Goldberg, 2016). The fast-paced healthcare environment, lack of clear policies and procedures, lack of role designation, and lack of up-to-date training contributed to missed identification (Appendix A). In fact, site data in a routinely high-volume, Level-1 designated trauma Pediatric Emergency Department in Baltimore demonstrated only 0.7% of eligible patients received a formal screen for CST over a one-month period with zero positively identified victims. This risk of oversight requires effective methods of identifying victims of CST to prevent further child sex exploitation and trauma.

The Short CST Screening Tool is a validated tool for patients who present in busy healthcare settings to determine the risk level for CST (American Academy of Pediatrics, 2021). The tool does not identify true victims with the screening tool alone, rather stratifies them to determine which patients warrant further evaluation. Screening eligibility includes patients between ages 11-17, English-speaking, and presenting with chief complaints of sexual health, mental health, traumatic injuries, and social service needs (Greenbaum, 2018). Application of the CST tool is also recommended at the discretion of the physician based on case-specific concerns.

Available Knowledge and Aims

The purpose of this Quality Improvement (QI) project is to identify patients at a high-risk for CST among pediatric patients in a tertiary Leve1-designated Pediatric Emergency Department in the mid-Atlantic region by implementation of the Short Screen for Child Sex Trafficking (SSCST) tool. Appendix B illustrates the current process and proposed process upon implementation of the interventions. In Appendix C, the PRISMA flowchart demonstrates the evidence search and retrieval process conducted to evaluate existing evidence of research studies that demonstrate the effectiveness of the Short CST tool. Using the CINAHL database, keywords such as “child”, “sex”, and “trafficking” were inputted with subsequent filtering of studies using exclusion criteria of adult studies, greater than seven years of the time of publication, lack of peer review, and irrelevance to study aims. Remaining studies were reviewed, and seven studies were included on the evidence retrieval based on relevance, design, and methods.

The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) rating scale was utilized to evaluation the quality and level of studies (Appendix D, Appendix E). A high-quality Level 1 study conducted by Greenbaum et al (2018) determined that patients with the following factors increased the risk of child sex exploitation: running away from home, prior law enforcement

involvement, history of STIs, history of drug/alcohol use, more than 5 sexual partners and a history of traumatic injuries requiring medical attention. Greenbaum et al (2018a) published a good-quality Level II study further supporting their initial findings. Application-based studies, such as those published by Hurst et al (2021, Kaltiso et al (2018), and Kennedy et al (2021), ranked as good quality Level II studies per the JHNEBP model. A level III good quality study by Gonzelez-Pons et al (2020) demonstrated individual beliefs about trafficking impacted victim identification. A Level III study by Ellis et al (2022) demonstrated two or more risk indicators increased the likelihood of identifying a positive CST victim. This compilation of evidence supports the utility of the Short CST tool in a busy tertiary, Leve1-designated Pediatric Emergency Department in Baltimore City.

Rationale

The Promoting Action of Research Implementation in Health Services (PARiHS) framework is designed to aid in the successful implementation of evidence into practice by evaluating three major domains: evidence, context of implementation, and facilitation of the process (Slaughter et al, 2013) (Appendix F). The “evidence” domain considers research, clinical experience, patient experience, and local information pertinent to the evidence. The context of implementation considers resources, infrastructure, culture, leadership, and orientation to learning and evaluation. Facilitation considers the facilitator roles and processes.

Implementation of evidence into practice by use of the PARiHS framework is applicable to the project site. Within the evidence domain, the site emphasizes use of evidence-driven clinical practice guidelines and institutional-specific protocols. As leaders in pediatric emergency care, clinicians are experienced in managing rare and complex cases with respect to family and patient preferences, even in high stress situations.

Within the domain of "context of implementation", the project site is a fast-paced and high-pressure environment, thus requires smooth integration of new changes with existing workflows. Leaders are engaged with evidence-based initiatives and evaluation processes are established to track outcomes and improve compliance with new initiatives.

Within the domain of "facilitation of the process", facilitators of initiatives include clinical educators, champions (ie. "super users"), and the Quality Improvement (QI) division. Facilitation of this initiative can be conducted by providing guidance to staff through unit-wide and individual training sessions.

Methods

Evaluation of the current site climate can identify site readiness for change prior to implementation. The *Readiness to Train Assessment Tool ("RTAT")* is a 41-item validated and reliable tool used to assess the site's cultural readiness to change by evaluating 7 domains using a Likert scale (strongly disagree "1" to strongly agree "5") (Community Health Center, Inc, 2021). Domain scores are averaged with the following correlations: "developing readiness" (score <2.99); "approaching readiness" (score 3.00-3.99), and "ready for change" (score > 4.00) (Community Health Center, Inc, 2021). The proposed site was assessed with the score outcomes in each domain: readiness to engage (4.6), financial resources (4.2), implementation team (4.7), implementation plan (4.3), evidence strength and quality of the proposed program (4.1), and access to additional resources that can be used to promote implementation success (4.9). With scores greater than 4.0 in all domains, this tool illustrates a site readiness for change.

The initial intention of this QI initiative was to implement the SSCST tool in the Pediatric Emergency Department, however during the early phases of implementation, members of the multidisciplinary team expressed concern over a lack of an available secondary screening tool

for patients stratified as “high-risk”. Team members favored the utilization of a secondary screening tool to increase confidence in identifying a “high-risk” patient’s true CST status after risk stratification. Guidance for a secondary screening tool is not part of the standard SSCST tool protocol, thus the primary project intervention of implementation of the screening tool were amended.

In the amended intervention, patients are not formally screened in a patient-provider interaction. However, the existing evidence and site data supports a dire need for sexual health resources for this vulnerable patient population. Thus, all patients who were otherwise eligible for the SSCST tool are intended to receive referrals for outpatient sexual health care clinics and sexual health care education without a formal stratification process.

SMART goals were developed (Appendix G) with a clear timeline for completion (Appendix H). In preparation for this protocol, the project lead successful collaborated with outpatient sexual health clinics to provide patients with access to self-referrals and development of hospital-approved sexual health education. Next, education regarding patient eligibility criteria and the workflow process was disseminated to an approximately eighty registered nurses (RNs). Rates of education was tracked using an RN attestation via survey link. At the end of the implementation period, an outcome goal of at least 50% of eligible patients who present at the site will have received a resource packet containing outpatient sexual health clinic self-referrals and sexual health education. Rates of resource distribution will be tracked using a scannable QR code that links to a survey for RN completion that confirms the patient received the intended resources. Additionally, by the end of the implementation period, average weekly rates of eligible patients who present in the Pediatric Emergency Department will be determined to support the ongoing implementation efforts of the SSCST tool. Finally, a structure goal focusing

on an administrative practice change that requires screening for CST of eligible patients will be initiated to provided focused resource distribution to high-risk patients and actual CST victims. Practice change can include, but not limited to, formal policy change, availability of SSCST tool within Epic, and "Best-Practice Alert" ("BPA") triggers for screening eligible patients.

Measurement

Successful implementation of the amended project outcomes depends on meeting outlined goals and requires ongoing measurement of major metrics of interest (Appendix I, Appendix J). Major metrics of interest include: (A) rate of RN education self-attestation; (B) average number of eligible patients who present at the project site; and (C) rate of resource packet distribution. Rates of RN attestation will be tracked on a self-reported survey link. The number of eligible patients will be tracked by filtering patient encounters in the ED by eligibility criteria (age and chief complaints). Rates of resource distribution will be tracked using a scannable QR code that links to a survey for RN completion that confirms the patient received the intended resources.

Analytics

Data was analyzed by the project lead through chart audits and REDCap surveys. Data collection and review of updated run charts occurred on a weekly basis. Data metrics were plotted on run charts to demonstrate patterns in trends over a 15-week period (Appendix K). Data was assessed for significant outliers and analyzed for notable trends. Significant events within the project timeframe were noted within the run charts. Meticulous and precise data collection occurred to avoid the risk of missing data and to ensure completeness.

Ethics

Patient information and privacy protection rights was maintained throughout the data collection and analysis phases. The Project Lead de-identified all patients included during all parts of the project. All data was stored in the encrypted program of REDCap without any identifiable patient information. Furthermore, the Project Lead maintained CITI and HIPAA training compliance throughout the duration of the project. There was no reported evidence of physical or psychological harm to those engaged in this quality improvement initiative.

This project contained the minimum necessary patient health information. Non-human Subject's Research determination from the Human Research Protections Office (HRPO) of the University of Maryland School of Medicine Institutional Review Board (IRB) was obtained prior to project implementation. In addition, project implementation at the site required review and approval by the Quality Improvement (QI) Clinical Inquiry Committee. The use of REDCap for all surveys and data collection ensures privacy and confidentiality by providing a secure, centralized platform with built-in data encryption and user access controls. All data was de-identified, accessible only to authorized personnel, and was destroyed at the conclusion of the project. Physical documents were stored in locked cabinets, while electronic data was stored on password protected secured servers. Conflicts of interest pertain to the project lead's paid employment with the project organization and on the project unit.

Results

Collected data is reflective of the initial QI metrics of interest and amended QI metrics of interest (Appendix K). In the pre-implementation phase of the initial QI initiative, a weekly average of 23.6 patients who were eligible for screening presented at the project site. In the first

week of implementation phase, five patients met eligibility criteria and one patient was stratified as “high-risk”, who also received outpatient resources (rate of eligible patient distribution: 20%).

At the time of implementation of the amended protocol, 32% of nurses completed an attestation of project education with a maximum of a 70% attestation rate by the end of the implementation period. On a weekly average, it was identified that 32 patients who were eligible for SSCST screening presented at the project site. Resource distribution rates varied between 0-10% throughout the implementation period and did not reach the goal of a 50% distribution rate.

Conclusions & Result Analysis

Though the intention of the initial initiative was to implement the Short Screen for Child Sex Trafficking (SSCST) to identify patients at a high-risk for child sex trafficking, unforeseen circumstances resulted in a discontinuation of the original protocol. Instead, an alternate initiative was developed to ensure at-risk patients could continue receiving outpatient sexual health referrals and resources despite the lack of a formal screening process. Review of the implementation data reveals several key findings. First, an increase in RN education review did not result in an increase in referral distribution rates. Additionally, fluctuations in the number of eligible patients who presented to the project site was not correlated with referral distribution rates. Distribution rates remained variable throughout the implementation period.

Between the time of the discontinuation of the initial protocol and implementation of the amended protocol, data regarding eligible patient presentation was not collected during the several weeks following protocol discontinuation. Thus, this contributes to missing data and it is inconclusive to state whether this data could have contributed to improved or worsened initiative outcomes since fluctuations in presentation rate is not correlated with referral distribution rate.

Discussion

Systemic barriers contributing to the low distribution rates of outpatient referrals closely mirror the challenges documented in the broader literature, particularly regarding low rates of screening and follow-up in emergency care settings (Goldberg, 2016). The most frequently cited obstacles were time constraints and consistently high patient volumes, both of which are inherent to a high-acuity, fast-paced pediatric emergency department. These factors created a clinical environment where nurses had limited capacity to identify eligible patients, provide education, and ensure the distribution of referrals within the ideal care window.

A particularly vulnerable population included lower-acuity patients, who, despite meeting eligibility criteria for outpatient referral, often experienced extended wait times and were at a higher risk of leaving the ED prior to being seen by either a provider or a bedside nurse. This not only represents a lost opportunity for intervention but also reflects a broader challenge in delivering equitable care across acuity levels in an overburdened setting.

During periods of peak patient influx, Advanced Practice Providers (APPs) played a crucial role in managing flow and reducing length of stay by independently discharging patients. However, in cases where this process occurred without nursing involvement, eligible patients were discharged without receiving referrals—furthering a gap in continuity and communication within the discharge workflow. Additionally, the sheer volume of eligible patients created a high demand for referral distribution, which exceeded the current operational capacity. Staff were often unable to keep pace with demand, contributing to systemic inefficiencies and variability in care delivery.

Another significant barrier was the absence of an automated eligibility notification within the Electronic Medical Record (EMR). Without system-generated prompts, the responsibility to

identify eligible patients fell solely on nursing staff recognition, further straining their capacity and increasing the risk of missed referrals. This manual process was both time-consuming and inconsistent, especially in the context of fluctuating patient volumes and staffing limitations.

To address these challenges and ensure long-term success, the Patient Education Committee, a dedicated departmental group focused on the development and distribution of health-related and safety patient education—will oversee the ongoing sustainability of this initiative. Future directions include the re-introduction of the Short Screen for Child Sex Trafficking (SSCST) and its integration into the EMR system. This will follow a structured re-training process and the successful demonstration of competence in CST screening by the multidisciplinary healthcare team. These efforts are intended to enhance workflow efficiency, reduce reliance on memory or manual tracking, and ultimately improve the consistency and reach of outpatient referral distribution.

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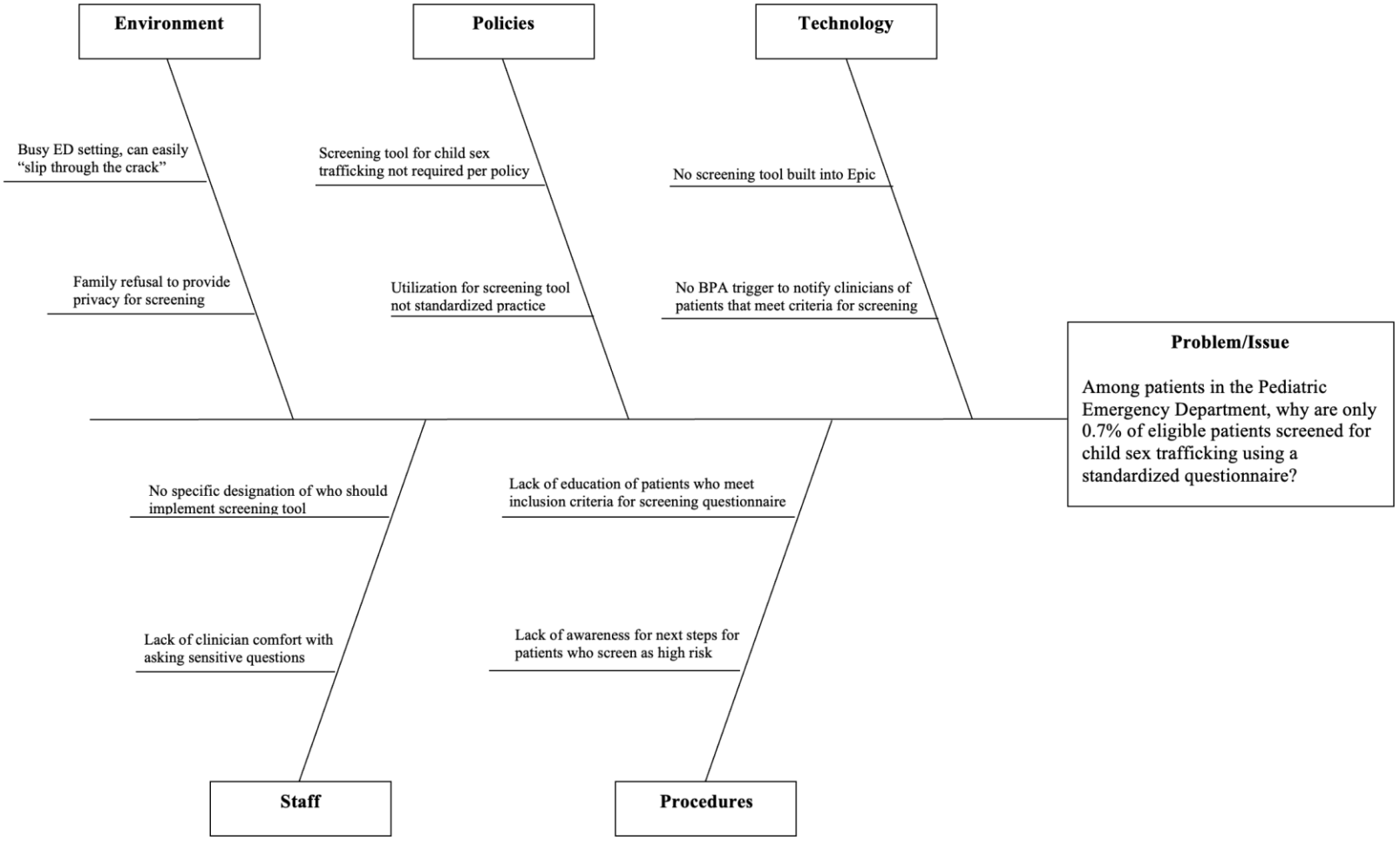
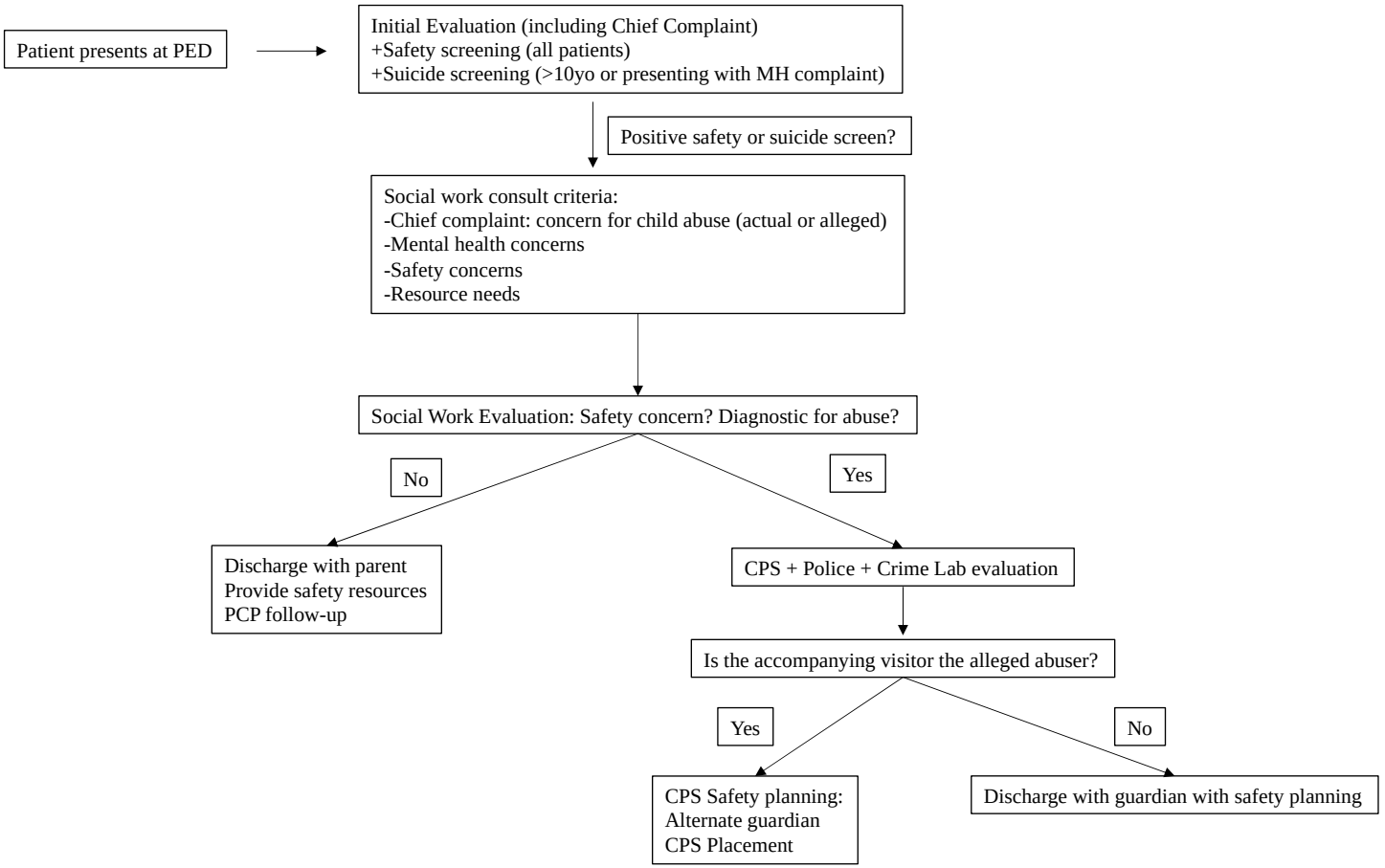
Appendix A

Fishbone Diagram – Causes and Sub-Causes of the Identified Issue

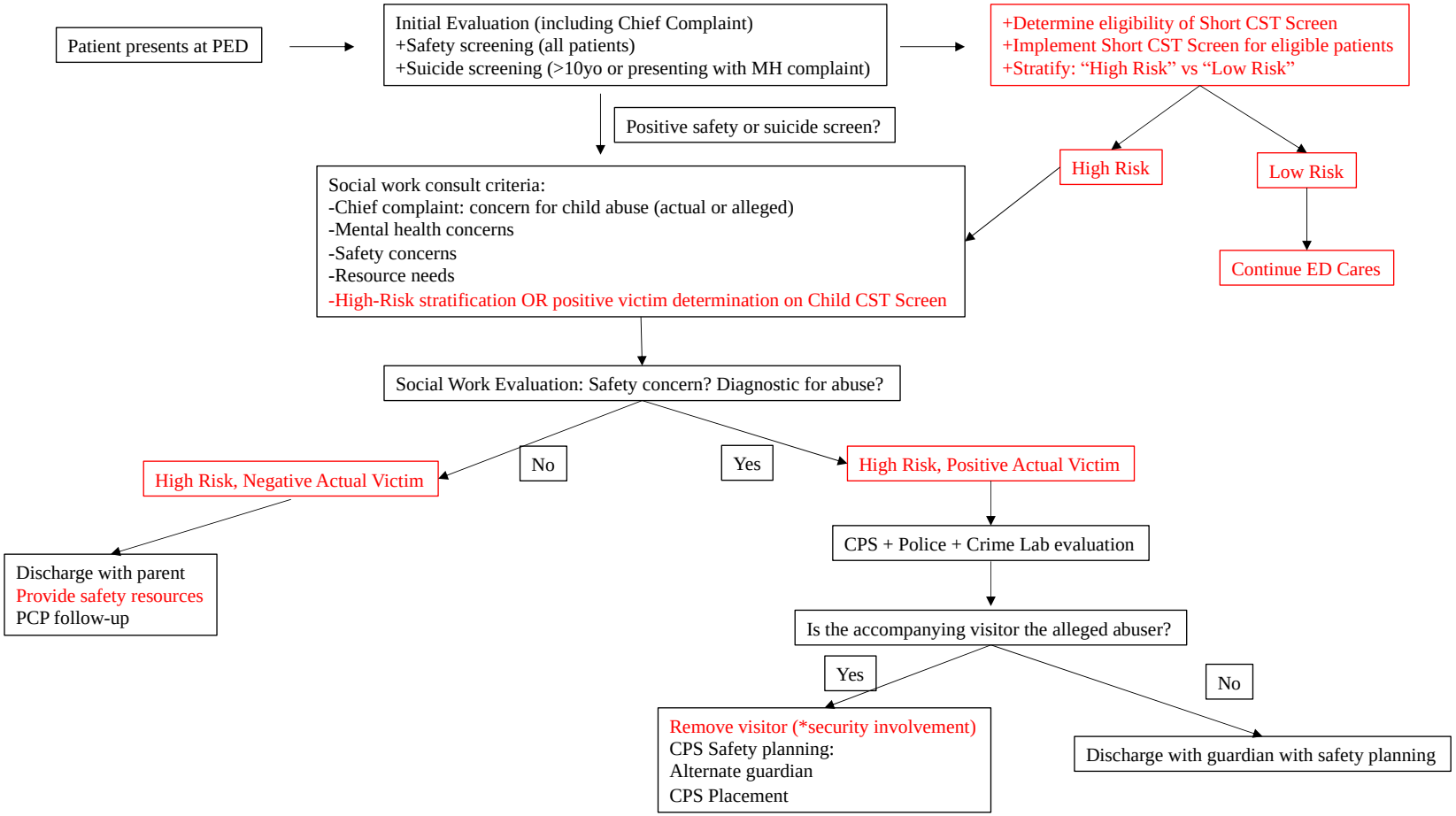


Appendix B

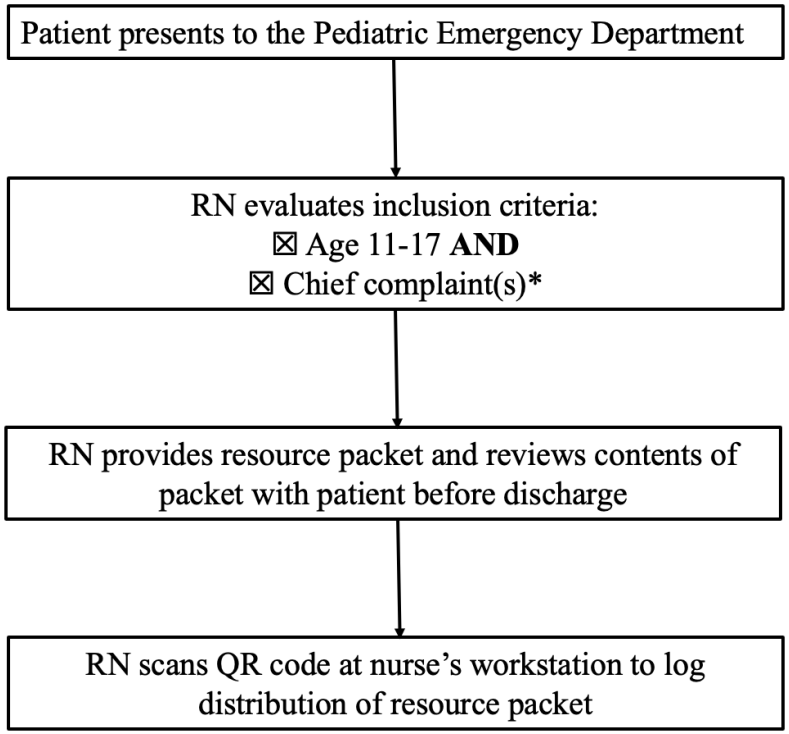
Current Process: General Safety Screen



Initial Proposed Process: Safety Screen + Short CST Screening tool Intervention



Amended Proposed Process: Eligible Patient Identification and Resource Distribution without Formal SSCST Screen

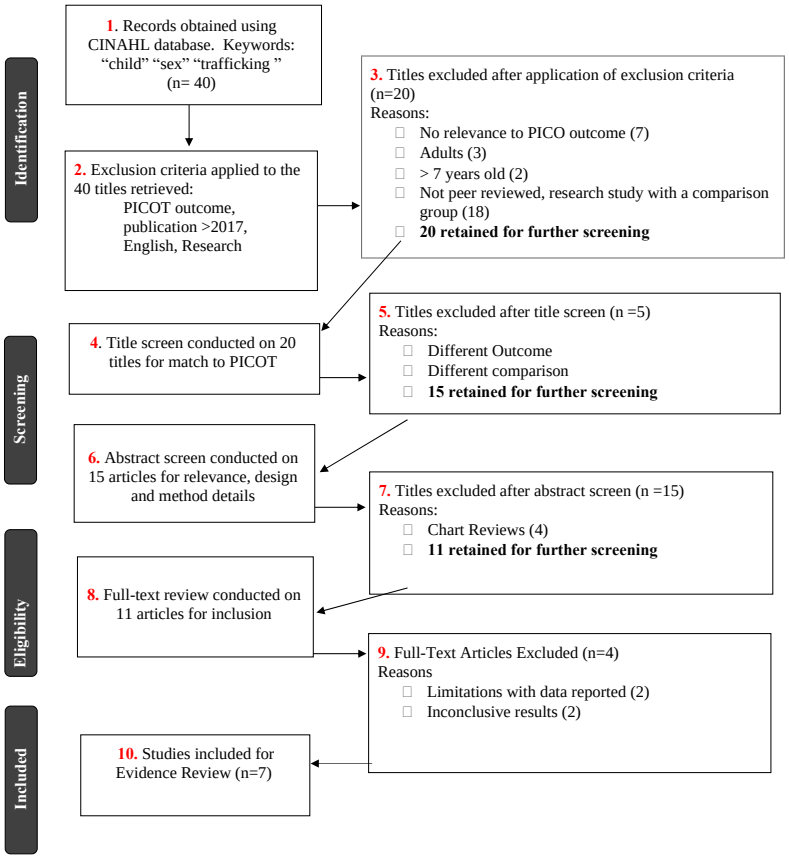


**Chief complaints as identified on SSCST tool inclusion criteria*

Appendix C

PRISMA

PRISMA Search Flow Diagram



Appendix D

Evidence Review Tables

Citation: Ellis, A. S., Brown, A. M., Martini, A. I., Page, E., Lin, L., & Vaughn, L. M. (2022). Application of a child sex trafficking screening tool in patients with abuse: A Retrospective Chart Review in the Pediatric Emergency Department. *Journal of Pediatric Health Care*, *36*(4), 330–338. https://doi.org/10.1016/j.pedhc.2022.01.002	**Level and Quality** Level III. Low Quality.
Purpose or Hypothesis	The purpose of this study was to review patient charts, aged 11 to 17 with a positive universal abuse screen, to identify if documentation of at least two CSEC/CST indicators were present.
Type of Evidence Research Design	Research. Retrospective chart review.
Sample Population, Size, Setting	**Sampling Technique:** Convenience sampling **Eligible Participants:** Patients aged 11-17 and positive universal abuse screens **Setting:** Midwestern, tertiary, pediatric medical center with two pediatric emergency departments and five urgent cares. **Excluded:** False positive abuse screens **Accepted:** 2,168 patients eligible. 153 randomly selected. **Control:** Patients with less than two risk factors based on documentation **Intervention:** Identification of patients with two or more risk factors based on documentation **Power analysis/Achieved:** 121 records needed to achieve adequate power. Power achieved with 153 records. **Group Homogeneity:** Mean age 15.06. Most patients were female, white, and non-Hispanic. A chief complaint of mental health was identified in 64.46% of respondents.
Intervention Procedures	**Control Protocol:** No control protocol. **Intervention Protocol:** Patient charts with the inclusion criteria were screened for presence of risk factors of child sex trafficking based on provider documentation. **Treatment Fidelity:** Constraints of retrospective review. Inconsistent charting. Lack of documentation may skew results.
Primary Outcome and Measures	**Dependent Variable:** Two or more risk indicators from the CSEC/CST screening tool **DV Measure:** Based on documentation within patient records from treating providers

Results/Conclusions	**Statistical Results:** Univariate analysis to determine associating variables that lead to the probability of 2+ indicators for this patient population. Multivariate analysis and correlation to determine the predictive odds of having two or more positive indicators. **Conclusions:** Univariate analysis testing showed seen variables were significantly associated with an increased probability of patients with two or more indicators on the CSEC/CST screening tool: older age, mental health chief complaint, history of being sexually active, history of drug/alcohol use, running aware from home, involvement with law enforcement, and history of sexually transmitted infection. Multivariate analysis testing indicated that age with runaway history predicted a 65.6% of the variance that a patient would have 2+ indicators. For a patient that is only one year older, the odds of having two or more positive indicators is more than 2.4 times greater than one year younger than them.

Citation: Greenbaum, V. J., Dodd, M., & McCracken, C. (2018a). A short screening tool to identify victims of child sex trafficking in the Health Care Setting. *Pediatric Emergency Care*, *34*(1), 33–37. https://doi.org/10.1097/pec.0000000000000602		**Level and Quality** Level II. Good Quality.
Purpose or Hypothesis	The purpose of this study is to describe characteristics of commercial sexual exploitation of children/child sex trafficking (CSEC/CST). A secondary purpose of this study is to develop a screening tool to identify adolescents who are at a high-risk for becoming victims of child sex trafficking.	
Type of Evidence Research Design	Research. Cross-sectional study.	
Sample Population, Size, Setting	**Sampling Technique:** Convenience sampling. **Eligible Participants:** English-speaking patients between ages 12 to 18 years old who present to one of three pediatric emergency departments or one child protection clinic and who were identified as victims of CSEC/CST were compared with patients of similar age and allegations of acute sexual assault/sexual abuse (ASA) without evidence of CSEC/CST. **Setting:** 1 of 3 metropolitan pediatric emergency departments or one child protection clinic **Excluded:** Extreme developmental delays, appearance of intoxication, or otherwise unable to answer questions accurately **Accepted:** 108 study participants **Control:** Given all eligible patients were screened without knowing CSEC/CST vs ASA, this study is unable to designate a true control population. **Intervention:** Variable combination of 50-questions that addressed demographics, appearance, medical history, review of systems, and sexual history. Questions were acceptably omitted if it was not applicable – ie. last time of drug use if declined ever having used drugs previously.	

	Power analysis/Achieved: not discussed **Group Homogeneity:** No statistical significance between age or gender between both groups, although there were more African Americans and "other" classified race in the CSEC/CST group compared to the ASA group.
Intervention Procedures	**Control Protocol:** Given all eligible patients were screened without knowing CST vs non-CST status, this study is unable to designate a true control population until after screening results are analyzed. **Intervention Protocol:** Review of history of the following: violence with parents, violence with others, history of fractures, history of inappropriate touching, history of violence with sex, violence between others at home, history of drug use history of running away, CPS history, history with police, physical examination injuries, positive STI testing, and positive toxicology screen. **Treatment Fidelity:** Limitation with generalizability in CSEC/CST population as all identified victims were domestically trafficked; no internationally trafficked victims identified. Small sample size. Not all questions were answered by participants. Vast majority of CSEC/CST victims were identified by authorities, so unclear whether results are generalizable.
Primary Outcome and Measures	**Dependent Variable:** Identification of CSEC/CST vs ASA without characteristics of CSEC/CST **DV Measure:** Positive predictability of CSEC/CST based on presenting characteristic and patient reported history
Results/Conclusions	**Statistical Results:** Of 14 identified characteristics among the CSEC/CST and ASA groups, multivariable logistic regression analysis yielded six characteristics with the greatest likelihood of identifying a positive CST victim when two questions were answered positively. Odds of identifying a true CST was 22 times higher when at least 2 questions were answered with "yes" compared to when there were less than two "yes" answers **Conclusions:** . Variables most likely to identify CSEC/CST victims were: presenting with any type of tattoo; lifetime history of fractures, significant wounds or traumatic loss of consciousness; history of sexual activity; history of violence by caregivers; history of 1 or more type of drugs use; run-away history; and history of involvement with law enforcement or CPS. Based on regression analysis, the following six-question tool has a high predictability of identifying CSEC/CST victims: 1. Is there a previous history of drug and/or alcohol use? 2. Has the youth ever run away from home? 3. Has the youth ever been involved with law enforcement? 4. Has the youth ever broken a bone, had traumatic loss of consciousness, or sustained a significant wound? 5. Has the youth ever had a sexually transmitted infection?

	6. Does the you have a sexual history of sexual activity with more than five partners? Study needs to be validated across multiple settings and population types, including multi-site studies in a variety of medical settings.

Citation: Greenbaum, V. J., Livings, M. S., Lai, B. S., Edinburgh, L., Baikie, P., Grant, S. R., Kondis, J., Petska, H. W., Bowman, M. J., Legano, L., Kas-Osoka, O., & Self-Brown, S. (2018). Evaluation of a tool to identify child sex trafficking victims in multiple healthcare settings. *Journal of Adolescent Health*, *63*(6), 745–752. https://doi.org/10.1016/j.jadohealth.2018.06.032	**Level and Quality** Level I. High Quality.
Purpose or Hypothesis	The purpose of this study is to evaluate the Short Child Sex Trafficking (CST) tool in a healthcare setting and estimate the prevalence of child sex trafficking (CST) among patients in multiple healthcare settings
Type of Evidence Research Design	Research. Cross-sectional observational study.
Sample Population, Size, Setting	**Sampling Technique:** Convenience sampling. **Eligible Participants:** English speaking. Ages 11-17 years old. For ED's: chief complaint of sexual violence. 930 patients were deemed eligible for the study. **Setting:** 16 urban healthcare sites across the United States: 5 pediatric emergency departments, 6 child advocacy centers, and 5 teen clinics **Excluded:** Extreme developmental delays, appeared intoxicated or in marked distress, those who declined to answer questions, those deemed unable to answer questions accurately by examiner. Previously surveyed participants were also excluded and when practitioner had time constraints. **Accepted:** 810 total study participants (ED – 91 participants, child advocacy centers – 395 participants, teen clinics – 324 participants) **Control:** Given all eligible patients were screened without knowing CST vs non-CST, this study is unable to designate a true control population. **Intervention:** The 6-item CST screening questions were embedded within a 17-item questionnaire. Additional questions beyond CST questions were geared towards demographics and medical care routines. **Power analysis/Achieved:** not discussed **Group Homogeneity:** Differences in age and female were statistically significant. All other characteristics regarding race and ethnicity were statistically insignificant.
Intervention Procedures	**Control Protocol:** Given all eligible patients were screened without knowing CST vs non-CST status, this study is unable to designate a true control population until after screening results are analyzed. **Intervention Protocol:** Study consent was obtained by participants with the understanding that all responses are given voluntarily. Some sites were able to gain participant concent without parental permission. A 17-item self-reported questionnaire was completed by each participant either on paper or

	electronic tablets privately without accompanying visitors. Follow-up questions to positive questions were conducted by the healthcare provider. **Treatment Fidelity:** IRB approval obtained for all participating institutions. Questionnaire completed on paper forms or electronic tablet. Participants answered questions privately from accompanying visitors. Of patients deemed true CST victims, healthcare providers gave detailed rationale for only 81% of patients; no rationale given for the remainder 19%. Large proportion of male participants (15.3%, 121 of 810 participants)
Primary Outcome and Measures	**Dependent Variable:** Identification of CST vs non-CST patients based on CST screening tool **DV Measure:** A positive answer to two or more CST questions was a considered a positive screen.
Results/Conclusions	**Statistical Results:** Two-tailed independent sample t-tests and one-way ANOVA tests were conducted for continuous variables. One-tailed X^2 tests were used to compare CST to non-CST participants with a 0.05 level of significance. All positive CST screening questions were found to be statistically significant for CST, except one regarding history of "broken bones/cuts needing stitches". The screen had an 84.4% specificity and 83.3% sensitivity in the total sample. **Conclusions:** Findings suggest that patients with multiple risk factors (running away from home, prior law enforcement involvement, history of STI's, >5 sexual partners, and/or drug/alcohol use) increase the likelihood of identifying a positive CST. Though the positive predictive value is low (15.9%), this is expected as further questioning is required to identify true CST patients. The author discusses that the ramifications of a false positive screen are minimal as further questioning can reduce the concern for a positive CST patient.

Citation: Gonzalez-Pons, K. M., Gezinski, L., Morzenti, H., Hendrix, E., & Graves, S. (2020). Exploring the relationship between domestic minor sex trafficking myths, victim identification, and service provision. Child Abuse & Neglect, 100, 104093. https://doi.	**Level and Quality** Level III. Good quality.
Purpose or Hypothesis	The purpose of this study is to determine of medical professionals are able to distinguish between myths and facts as it pertains to sex trafficking and if their knowledge impacts the care their patient(s) receive.
Type of Evidence Research Design	Research. Cross-sectional survey.

Sample Population, Size, Setting	**Sampling Technique:** Convenience **Eligible Participants:** Professionals serving in youth-focused organizations. Includes professionals from the following sectors: housing, education, faith-based, law enforcement, legal, medical/public health, mental health, professional associations, substance abuse treatment, victim assistance. Also specifies provider roles within the organization: administration, case manager, clinician, direct service, support staff. Total of 69 service providers. **Setting:** 29 organizations within a large metropolitan city in the Southwest region of the United States **Excluded:** Individuals outside of the sectors listed above **Accepted:** 69 individuals **Control:** None **Intervention:** Survey regarding perceptions of characteristics of victims of human trafficking **Power analysis/Achieved:** Not discussed **Group Homogeneity:** Reported 78% of female respondents and 21% male respondents. Survey ranged across six organizational roles and the majority of respondents belonged to six represented community sectors.
Intervention Procedures	**Control Protocol:** No control. All respondents were given the same survey. **Intervention Protocol:** Respondents were given 8 true/false/neutral questions directed at the participant's belief of required characteristics to classify one as a domestic minor sex trafficking victim. **Treatment Fidelity:** No study control, which reduces the study's internal validity.
Primary Outcome and Measures	**Dependent Variable:** Survey outcome distributions **DV Measure:** Represented by percentage values of true, false, or neutral
Results/Conclusions	**Statistical Results:** Statistical significant result between the belied that elements of physical force, restraint, bondage, and/or violence are needed to identify child sex trafficking victims and the number of victims their organizations served in a given year. **Conclusions:** Major challenge to identifying human trafficking victims relates to individual beliefs of how a trafficked youth presents, complex legislation, distortion of human trafficking victims in the media, and lack of victim disclosures. Study is consistent with previous research that demonstrates individual beliefs of myths impacts identification of victims. Consider implementation of a standardized screening tool to aide in the identification of child trafficking victims to eliminate personal biases or expecations about how a victim should present.

Citation: Hurst, I. A., Abdoo, D. C., Harpin, S., Leonard, J., & Adelgais, K. (2021). Confidential screening for sex trafficking among minors in a pediatric emergency department. *Pediatrics*, *147*(3). https://doi.org/10.1542/peds.2020-013235	**Level and Quality** Level II. Good Quality.

Purpose or Hypothesis	The purpose of this study was to confidently administer the validated Short Child Sex Trafficking (CST) tool in an emergency department setting using an electronic tablet to identify minors at high-risk for sex trafficking. The hypothesis of this study was that utilizing the modality of an electronic tablet would adequately and appropriately identify high risk patients.
Type of Evidence Research Design	Research. Prospective cohort.
Sample Population, Size, Setting	**Sampling Technique:** Convenience sample. **Eligible Participants:** 12- to 17-year old English and Spanish speaking subjects between February 2019 and March 2020. Eligibility criteria included: presented alone, presented for psychiatric or genitourinary complaints, sexual abuse, sexual assault, or law enforcement concerning for trafficking. 377 patients screens and 214 were enrolled. **Setting:** Urban, regional, freestanding children's hospital classified as a tertiary care level 1-verified trauma center with a census of about 80,000 patients per year. On site professionals included licensed psychiatric clinicians, psychiatrists, 24-hour sexual assault nurse examiners, clinical social workers, and research assistants. **Excluded:** Altered mental status, hallucinations, developmental or cognitive delays, or minor trauma. Of screened patients, 76 were not eligible. **Accepted:** n = 212 **Control:** Given all eligible patients were screened without knowing CST vs non-CST, this study is unable to designate a true control population. **Intervention:** Implementation of CST tool on an electronic tablet **Power analysis/Achieved:** 575 subjects are needed for a trafficking prevalence of 4%. 422 subjected are needed for a prevalence of 11%. The study enrolled 212 subjects – power for this study was unmet, **Group Homogeneity:** Among the CST and non-CST groups, sex was found to be an insignificant demographic. Age and race were significant demographics.
Intervention Procedures	**Control Protocol:** Given all eligible patients were screened without knowing CST vs non-CST status, this study is unable to designate a true control population until after screening results are analyzed. **Intervention Protocol:** Study subjected completed the 6-item screening tool on an electronic tablet. **Treatment Fidelity:** No true control in this study. Findings were compared to previously reported methods of screening administration.
Primary Outcome and Measures	**Dependent Variable:** Identification of CST vs non-CST patients based on CST screening tool administered on electronic tablet. **DV Measure:** Of the six questions on the screening tool, two positive answers classified a patient as "positive CST".

Results/Conclusions	**Statistical Results:** The study found there is an additional 12.3% prevalence of child sex trafficking when administered confidentially via electronic tablet compared to previous study reports administering the questionnaire as an in-person interview. **Conclusions:** Minors at a high risk of child sex trafficking can be accurately identified using an electronic tablet to administer the questionnaire compared to in-person interviewing.

Citation: Kennedy, M. A., Arebalos, M. R., Ekroos, R. A., & Cimino, A. N. (2021). Sex Trafficking Red Flags:: Confirming Presentation Patterns and Childhood Adversity Risk Factors. *Nurse Leader*, *19*(5), 516–520. https://doi.org/10.1016/j.mnl.2021.01.007	**Level and Quality** Level II. Good Quality.
Purpose or Hypothesis	The purpose of this study is to confirm risk factors outlined in the Greenbaum CST screening tool in a large sample of young adults who were confirmed to have been trafficked as minors.
Type of Evidence Research Design	Research. Cross-sectional survey.
Sample Population, Size, Setting	**Sampling Technique:** Retrospective case study. **Eligible Participants:** young adults (ages 18 to 24) recruited via local service providers working with trafficking victims who self-identified as sex-trafficking victims as a minor **Setting:** Geographical setting not discussed. **Excluded:** No history of child sex trafficking **Accepted:** 96 young adults **Control:** Not discussed **Intervention:** Completion of online survey **Group Homogeneity:** Reported diversity of participants: 35% African American, 31% Latino, 19% Caucasian, 15% mixed or other race. Average age of 20.23 years old. 91 females and 5 males.
Intervention Procedures	**Control Protocol:** not discussed **Intervention Protocol:** Completion of survey endorsing the presence of characteristics listed on screening tools **Treatment Fidelity:** No control group. Lack of comprehensive statistical analysis.
Primary Outcome and Measures	**Dependent Variable:** Survey responses from previous victims of child sex trafficking **DV Measure:** Frequency of screening tool items expressed as a percentage. More than two positive answers to the questions is considered a positive screen
Results/Conclusions	**Statistical Results:** 78.4% of participants would be considered as a positive screen using the Greenbaum CST screening tool

	Conclusions: The Greenbaum CST tool asks questions relevant to trafficked youth experiences. There is a limited number of clinically-oriented tools available to confirm screening items to trafficked youth experiences.

Citation: Kaltiso, S. O., Greenbaum, V. J., Agarwal, M., McCracken, C., Zmitrovich, A., Harper, E., & Simon, H. K. (2018). Evaluation of a screening tool for child sex trafficking among patients with high-risk chief complaints in a pediatric emergency department. *Academic Emergency Medicine*, *25*(11), 1193–1203. https://doi.org/10.1111/acem.13497	**Level and Quality** Level II. Good quality.
Purpose or Hypothesis	The purpose of this study was to implement the Short Child Sex Trafficking (CST) screening tool in a pediatric emergency department to identify patients at a high risk for child sex trafficking.
Type of Evidence Research Design	Research. Prospective observational study.
Sample Population, Size, Setting	**Sampling Technique:** Convenience sampling **Eligible Participants:** English speaking patients. Age 10-18 years old. Presenting chief complaints including: vaginal/penile discharge, pelvic/genital pain, request for STI testing, request for pregnancy testing, intoxication, ingestion, suicide attempt, suicidal ideation, homicidal ideation, concerns for sexual assault, concerns for traumatic assault, clearance examination for social services, and behavioral complaints. Attending physician concerns based on patient conversation and interaction. **Setting:** Free-standing inner-city children's hospital in a pediatric emergency department **Excluded:** Non-English speaking. Patients with intellectual disabilities or cognitive delays. Patients presenting with acute emergencies, severe pain, or need for medical stabilization. Exclusion based on attending physician discretion (ie. patient too young to be asked about sexual history or drug use) **Accepted:** 203 patients **Control:** Given all eligible patients were screened without knowing CST vs non-CST, this study is unable to designate a true control population. Upon determination of CST vs non-CST victims, demographics, risk factors, chief complaints, and final diagnoses compared to determine statistical significance **Intervention:** Implementation of CST tool to eligible patients **Power analysis/Achieved:** Sample size of 220 patients needed to demonstrate sensitivity and specificity of 80% for adequate power. Study total sample size was 203, thus did not meet proposed 220 patients to achieve adequate power. **Group Homogeneity:** Among patient demographics, 3 of 4 were found to be statistically insignificant between non-CST and CST patients.
Intervention Procedures	**Control Protocol:** Given all eligible patients were screened without knowing CST vs non-CST status, this study is unable to designate a true control population until after screening results are analyzed. **Intervention Protocol:** All eligible patients received the CST screening tool and were stratified as either CST or non-CST **Treatment Fidelity:** Researchers obtained patient consent to study prior to participation. Researchers were independent from patient care team. Patients previously identified as CST were not re-interviewed. Questionnaire implemented privately from accompanying visitors. True CST victims were identified if

	information provided by the patient fulfilled the federal definition of child sex trafficking (exchange of sex for money, food, shelter, luxury items; involvement in production of child sexual abuse materials; performing sex-oriented business).
Primary Outcome and Measures	**Dependent Variable:** Identification of CST vs non-CST patients based on CST screening tool **DV Measure:** Of the six questions on the screening tool, two positive answers classified a patient as "positive CST". The exception to this is if the patient answers a "yes" to for following question: "does the youth have a history of sexual activity with more than five partners?". Even if this is the only positive question on the screen, it automatically classifies the subject as positive CST.
Results/Conclusions	**Statistical Results:** CST screening tool characteristics were calculated (sensitivity, PPV, and NPV) with a 95% confidence interval. Demographics of CST and non-CST patients were compared using two sample t-tests or Wilcoxon rank sum tests. Chi-square tests were used for categorical variables. With a cutoff score of two positive answers, the CST screening tool demonstrated a 90.9% sensitivity, 53.1% specificity, 10.0% PPV, 99.0% NPV, 9.1% false-negative rate, and 46.9% false-positive rate. Demographics with strong associations with CST victims include: history of running away from home, history of drug/alcohol use, more than 5 sexual partners, history of sexually transmitted infection, and a "sexual" final diagnosis. **Conclusions:** Though the study showed high sensitivity, it did not meet the 80% benchmark for specificity due to decreased power related the number of required study participants (220 needed vs 203 actual). The study concludes that the CST screening tool is effective at excluding CST and identify potential victims on additional screening, however it does not identify true victims of CST. The study author discusses this is an expected outcome to prevent missing potential true positive victims based on a screening tool alone. Ongoing discussion with the positive CST patients are required to determine true CST victims. It is also important to consider many CST victims are reluctant to self-identify given the complex nature of trafficking, including fear from traffickers and lack of trust in authorities. Furthermore, the child may not consider their circumstances as "child trafficking", thus do not consider themselves as victims to exploitative situations.

Evidence Synthesis

Project Title: Identification of patients at high-risk for child sec trafficking using the Short Child Sex Trafficking (CST) screening tool			
PICOT: Among adolescents aged 11-17, how does the use of the Child Sex Trafficking (CST) screening tool compared to no use of a standardized tool, affect a medical provider's ability to identify youth's at high-risk for child sex trafficking?			
JHNEBP Model Level	**Total Number of Sources**	**Author and Quality Rating of each study**	**Synthesis of Findings**
Level 1 Experimental study · Randomized Controlled Trial (RCT) · Systematic review of RCTs with or without meta-analysis	1	Greenbaum et al (2018) – High Quality	Findings suggest that patients with multiple risk factors (running away from home, prior law enforcement involvement, history of STI's, >5 sexual partners, and/or drug/alcohol use) increase the likelihood of identifying a positive CST. Though the positive predictive value is low (15.9%), this is expected as further questioning is required to identify true CST patients. The author discusses that the ramifications of a false positive screen are minimal as further questioning can reduce the concern for a positive CST patient.
Level II Quasi-experimental studies · Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis	5	Hurst et al (2021) – Good Quality Kaltiso et al (2018) – Good Quality	Minors at a high risk of child sex trafficking can be accurately identified using an electronic tablet to administer the questionnaire compared to in-person interviewing. The study concludes that the CST screening tool is effective at excluding CST and identify potential victims on additional screening, however it does not identify true victims of CST. The study author discusses this is an expected outcome to prevent missing potential true positive victims based on a screening tool

			alone. Ongoing discussion with the positive CST patients are required to determine true CST victims.
		Greenbaum et al (2018a) – Good Quality	Variables most likely to identify CSEC/CST victims were: presenting with any type of tattoo; lifetime history of fractures, significant wounds or traumatic loss of consciousness; history of sexual activity; history of violence by caregivers; history of 1 or more type of drugs use; run-away history; and history of involvement with law enforcement or CPS. The Greenbaum CST tool asks questions relevant to trafficked youth experiences. There is a limited number of clinically-oriented tools available to confirm screening items to trafficked youth experiences.
		Kennedy et al (2021) – Good quality	
Level III Non-experimental study · Systematic review of a combination of RCTs, quasi-experimental, and non-experimental studies, or non-experimental studies only,	1	Gonzalez-Pons et al (2020) – Good quality	Major challenge to identifying human trafficking victims relates to individual beliefs of how a trafficked youth presents, complex legislation, distortion of human trafficking victims in the media, and lack of victim disclosures. Study is consistent with previous research that demonstrates individual beliefs of myths impacts identification of victims. Consider implementation of a standardized screening tool to aide in the identification of child

with or without meta-analysis · Qualitative study or systematic review of qualitative studies with or without meta-synthesis		Ellis et al (2022) – Low quality	trafficking victims to eliminate personal biases or expectations about how a victim should present. Univariate analysis testing showed seen variables were significantly associated with an increased probability of patients with two or more indicators on the CSEC/CST screening tool: older age, mental health chief complaint, history of being sexually active, history of drug/alcohol use, running aware from home, involvement with law enforcement, and history of sexually transmitted infection. Multivariate analysis testing indicated that age with runaway history predicted a 65.6% of the variance that a patient would have 2+ indicators. For a patient that is only one year older, the odds of having two or more positive indicators is more than 2.4 times greater than one year younger than them.
Level IV Opinion of respected authorities and/or reports of nationally recognized expert committees/consensus panels based on scientific evidence	0		
Level V Evidence obtained from literature reviews, quality improvement, program evaluation, financial evaluation, or case reports · Opinion of nationally recognized expert(s) based on experiential evidence	0		
Overall Quality Rating w/rational and Recommendation: Good. The majority of studies are able to statistically support the usefulness			

of the 6-item Short Child Sex Trafficking screening tool with good quality data. Considering randomized control trials are unethical in this particular area of research, a limitation of a true experimental study exists. However, most of the reviewed studies are able to near-consistently produce evidence that the screening tool is able to identify patients at a high-risk for child sex trafficking in a busy pediatric emergency department setting. Based on the evidence, there is good and consistent evidence with a practice change recommendation.
Recommendations Based on Evidence Synthesis • Strong, compelling evidence, consistent results: solid indication for a practice change. • Good and consistent evidence – practice change • Good but conflicting evidence: questionable indication for practice change; consider risk/benefit analysis • Little or no evidence: no indication for practice change

Appendix E

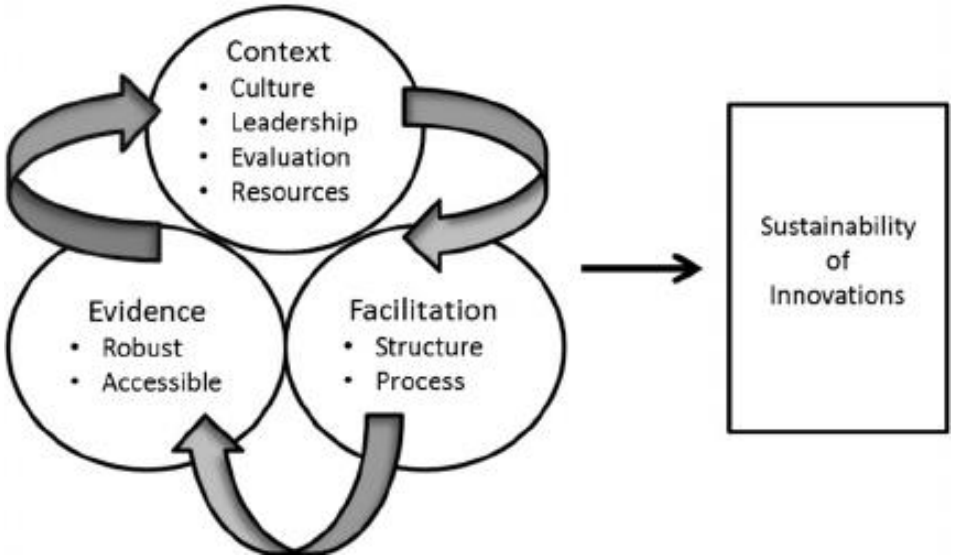
Mendeley Reference Manager

All References

AUTHORS	YEAR	TITLE	SOURCE
Gonzalez-Pons K, Ge…	2020	Exploring the relationship between domestic minor sex trafficking myths, victim identification, and service provision	Child Abuse & Neglect
Kennedy M, Arebalos …	2021	Sex Trafficking Red Flags:	Nurse Leader
Ellis A, Brown A, Marti…	2022	Application of a Child Sex Trafficking Screening Tool in Patients with Abuse: A Retrospective Chart Review in the Pediatric Emergency Department	Journal of Pediatric Health Care
Greenbaum V, Dodd …	2018	A Short Screening Tool to Identify Victims of Child Sex Trafficking in the Health Care Setting	Pediatric Emergency Care
Greenbaum V, Living…	2018	Evaluation of a Tool to Identify Child Sex Trafficking Victims in Multiple Healthcare Settings	Journal of Adolescent Health
Kaltiso S, Greenbaum…	2018	Evaluation of a Screening Tool for Child Sex Trafficking Among Patients With High-Risk Chief Complaints in a Pediatric Emergency Department	Academic Emergency Medicine
Hurst I, Abdoo D, Har…	2021	Confidential Screening for Sex Trafficking Among Minors in a Pediatric Emergency Department	Pediatrics

Appendix F

Framework: *Promoting Action of Research Implementation in Health Services (PARiHS)*



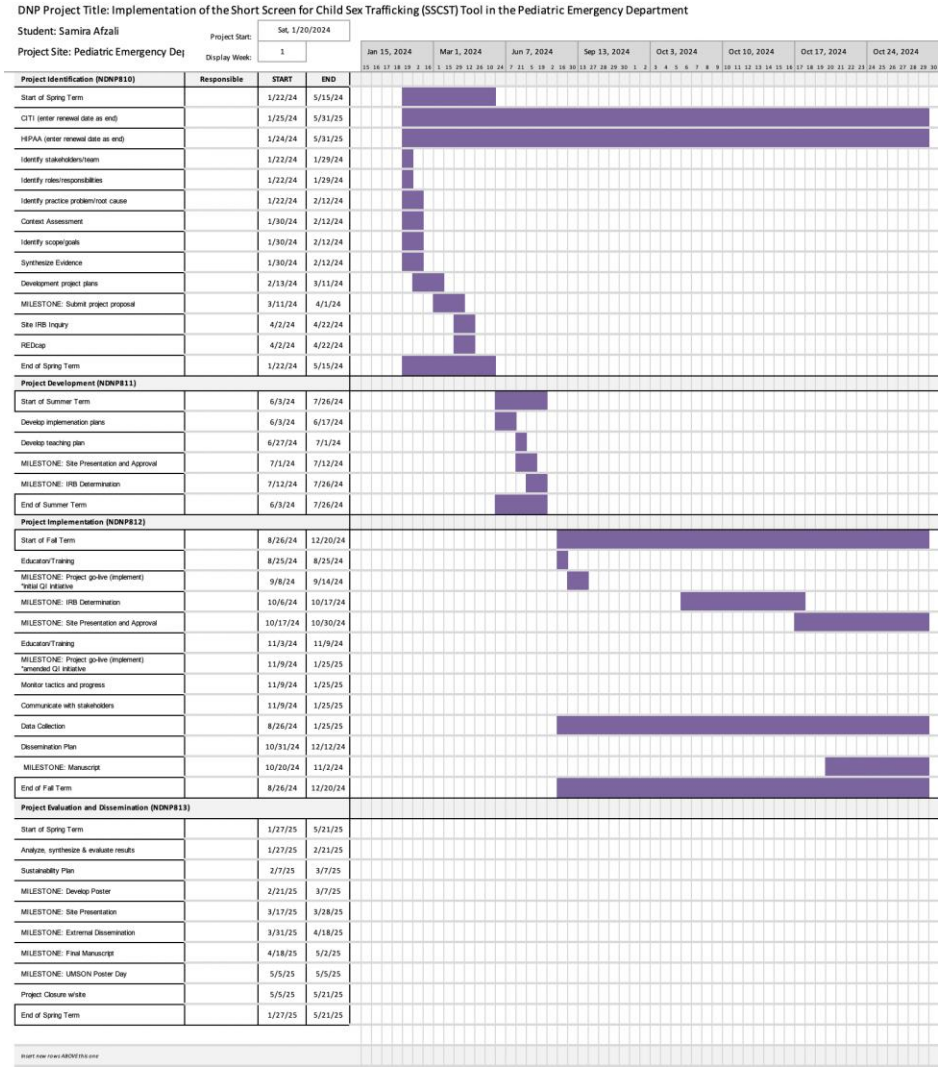
Appendix G

Measurement Instruments/Tools

Project Structure, Process, Outcome Goals	Measurement Procedures (who will collect data, when, how, from where)
1. Collaboration with outpatient sexual health clinics to provide patients with access to self-referrals; acquisition of hospital-approved sexual health education	Who: Project Lead When: Prior to project go-live How: Collaboration with local outpatient sexual health clinics From Where: Local contacts
2. Nursing education: Patient Eligibility	Who: Project Lead When: Prior to project go-live How: RN self-attestation From Where: RedCAP survey link
3. Nursing education: Modified workflow	Who: Project Lead When: Prior to project go-live How: RN self-attestation From Where: RedCAP survey link
4. At least 50% of eligible patients will receive a resource packet containing outpatient referrals and education	Who: Project Lead When: At time of resource distribution How: Logged by the RN From Where: scannable QR code linked to RedCAP survey
5. Identification of average number of eligible patients who present at the project site per week	Who: Project Lead When: Weekly on Sundays How: Chart Audits From Where: EPIC EMR
6. Initiation of collaborative efforts for administrative practice change to require formal SSCST screen	Who: Project Lead, PED Leadership, PED Social Work, Hospital Leadership, IT When: After data collected How: Utilization of data analysis to demonstrate ongoing need for SSCST screen From Where: Hospital policy database

Appendix H

Timeline GANTT



DNP Project Title: Implementation of the Short Screen for Child Sex Trafficking (SSCST) Tool in the Pediatric Emergency Department

Student: Samira Afzali

Project Site: Pediatric Emergency Dep

Project Start: Sat, 1/20/2024

Display Week: 8

Project Identification (NDNP810)	Responsible	START	END
Start of Spring Term		1/22/24	5/15/24
CITI (enter renewal date as end)		1/25/24	5/31/25
HIPAA (enter renewal date as end)		1/24/24	5/31/25
Identify stakeholders/team		1/22/24	1/29/24
Identify roles/responsibilities		1/22/24	1/29/24
Identify practice problem/root cause		1/22/24	2/12/24
Context Assessment		1/30/24	2/12/24
Identify scope/goals		1/30/24	2/12/24
Synthesize Evidence		1/30/24	2/12/24
Development project plans		2/13/24	3/11/24
MILESTONE: Submit project proposal		3/11/24	4/1/24
Site IRB Inquiry		4/2/24	4/22/24
REDcap		4/2/24	4/22/24
End of Spring Term		1/22/24	5/15/24
Project Development (NDNP811)			
Start of Summer Term		6/3/24	7/26/24
Develop implementation plans		6/3/24	6/17/24
Develop teaching plan		6/27/24	7/1/24
MILESTONE: Site Presentation and Approval		7/1/24	7/12/24
MILESTONE: IRB Determination		7/12/24	7/26/24
End of Summer Term		6/3/24	7/26/24
Project Implementation (NDNP812)			
Start of Fall Term		8/26/24	12/20/24
Educaton/Training		8/25/24	8/25/24
MILESTONE: Project go-live (implement) "Initial QI initiative		9/8/24	9/14/24
MILESTONE: IRB Determination		10/6/24	10/17/24
MILESTONE: Site Presentation and Approval		10/17/24	10/30/24
Educaton/Training		11/3/24	11/9/24
MILESTONE: Project go-live (implement) "amended QI initiative		11/9/24	1/25/25
Monitor tactics and progress		11/9/24	1/25/25
Communicate with stakeholders		11/9/24	1/25/25
Data Collection		8/26/24	1/25/25
Dissemination Plan		10/31/24	12/12/24
MILESTONE: Manuscript		10/20/24	11/2/24
End of Fall Term		8/26/24	12/20/24
Project Evaluation and Dissemination (NDNP813)			
Start of Spring Term		1/27/25	5/21/25
Analyze, synthesize & evaluate results		1/27/25	2/21/25
Sustainability Plan		2/7/25	3/7/25
MILESTONE: Develop Poster		2/21/25	3/7/25
MILESTONE: Site Presentation		3/17/25	3/28/25
MILESTONE: Extremal Dissemination		3/31/25	4/18/25
MILESTONE: Final Manuscript		4/18/25	5/2/25
MILESTONE: UMSON Poster Day		5/5/25	5/5/25
Project Closure w/site		5/5/25	5/21/25
End of Spring Term		1/27/25	5/21/25

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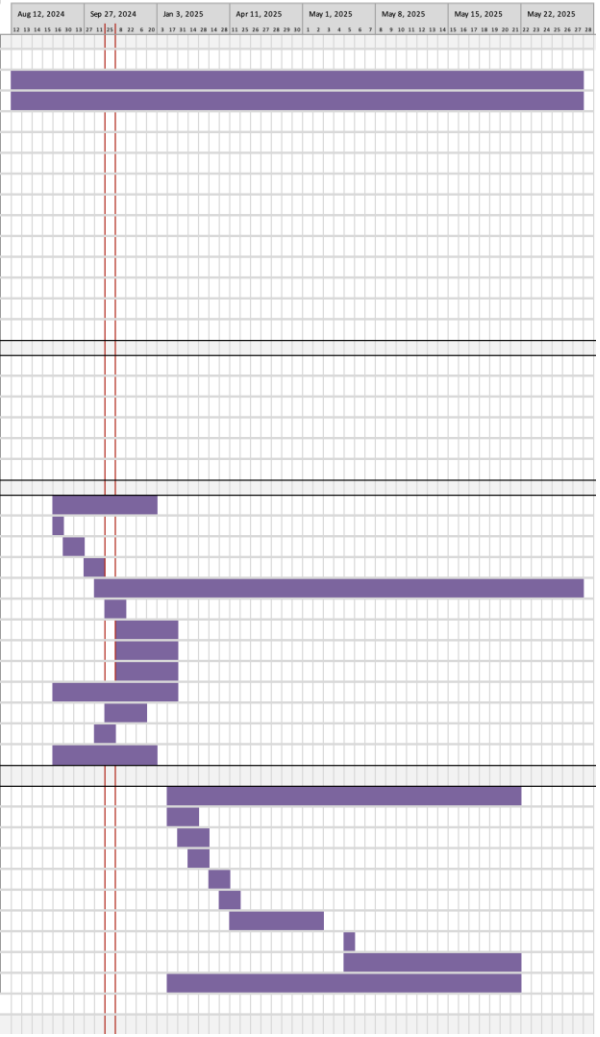
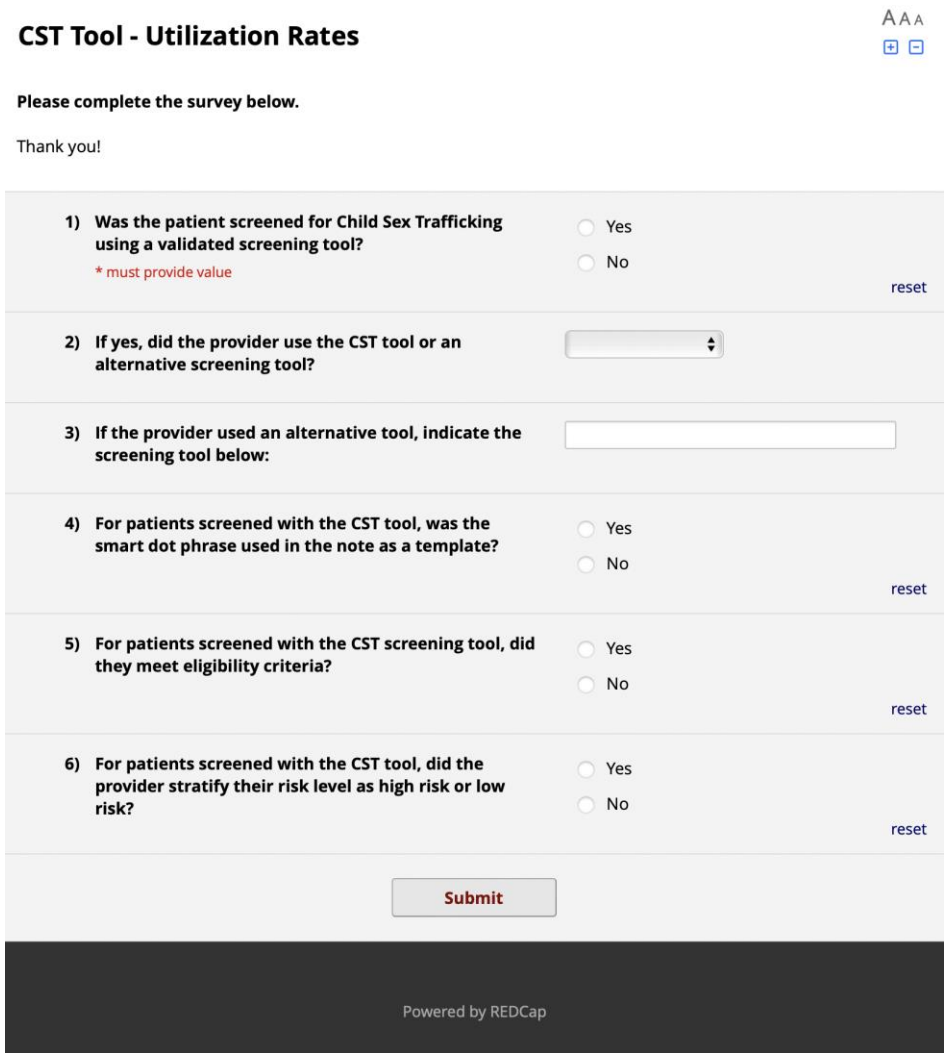


Appendix I

Measurement Tools – Initial QI Initiative; Implementation of SSCST Tool (weeks 1-4)



CST Tool - Utilization Rates

AAA

Please complete the survey below.

Thank you!

1) **Was the patient screened for Child Sex Trafficking using a validated screening tool?**
   * must provide value
   ○ Yes
   ○ No
   reset

2) **If yes, did the provider use the CST tool or an alternative screening tool?**

3) **If the provider used an alternative tool, indicate the screening tool below:**

4) **For patients screened with the CST tool, was the smart dot phrase used in the note as a template?**
   ○ Yes
   ○ No
   reset

5) **For patients screened with the CST screening tool, did they meet eligibility criteria?**
   ○ Yes
   ○ No
   reset

6) **For patients screened with the CST tool, did the provider stratify their risk level as high risk or low risk?**
   ○ Yes
   ○ No
   reset

Submit

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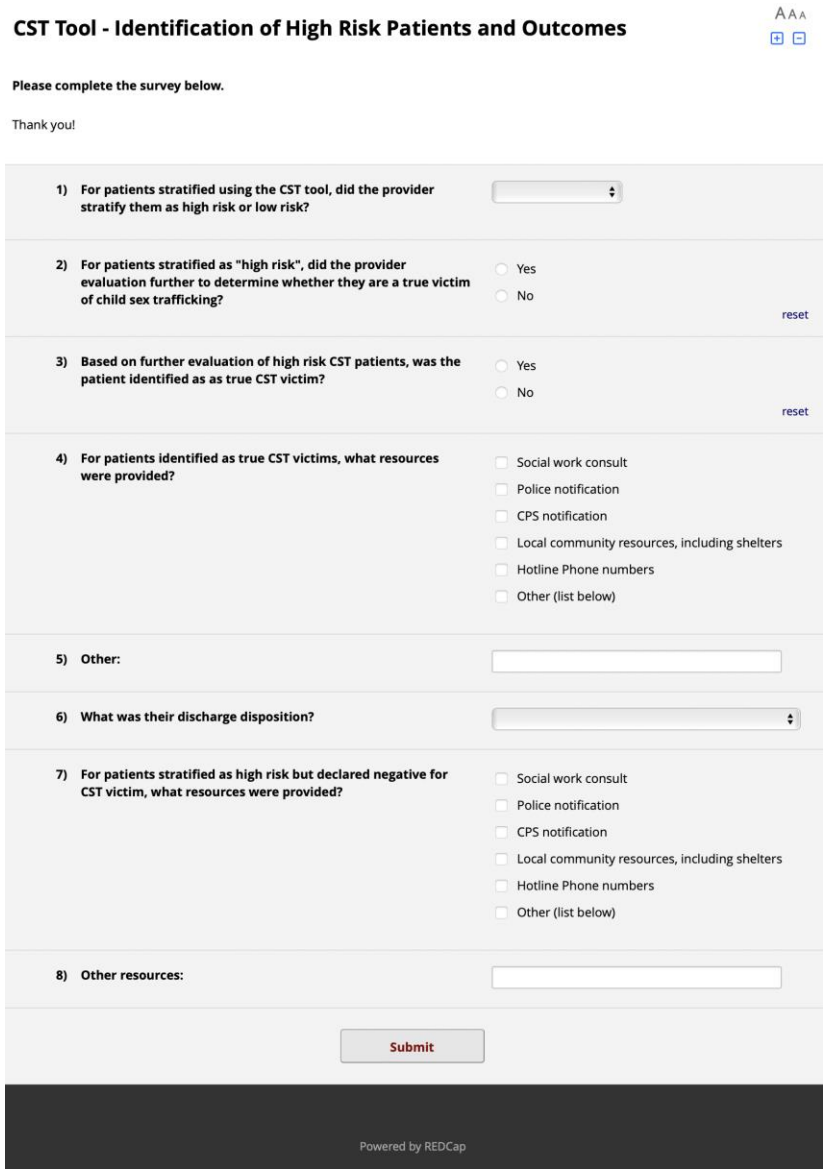

CST Tool - Identification of High Risk Patients and Outcomes

Please complete the survey below.

Thank you!

1) **For patients stratified using the CST tool, did the provider stratify them as high risk or low risk?**

2) **For patients stratified as "high risk", did the provider evaluation further to determine whether they are a true victim of child sex trafficking?**
- Yes
- No

reset

3) **Based on further evaluation of high risk CST patients, was the patient identified as as true CST victim?**
- Yes
- No

reset

4) **For patients identified as true CST victims, what resources were provided?**
- Social work consult
- Police notification
- CPS notification
- Local community resources, including shelters
- Hotline Phone numbers
- Other (list below)

5) **Other:**

6) **What was their discharge disposition?**

7) **For patients stratified as high risk but declared negative for CST victim, what resources were provided?**
- Social work consult
- Police notification
- CPS notification
- Local community resources, including shelters
- Hotline Phone numbers
- Other (list below)

8) **Other resources:**

Submit

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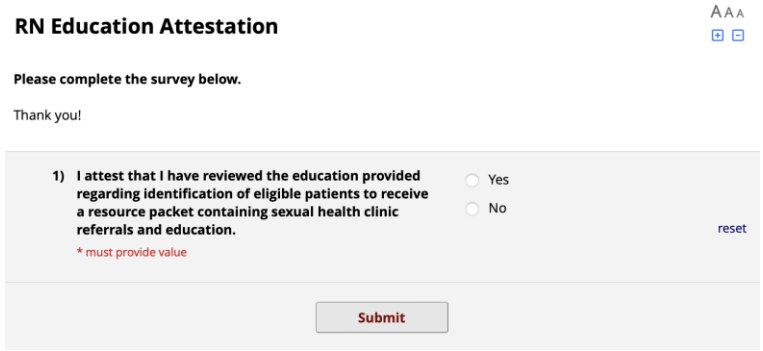
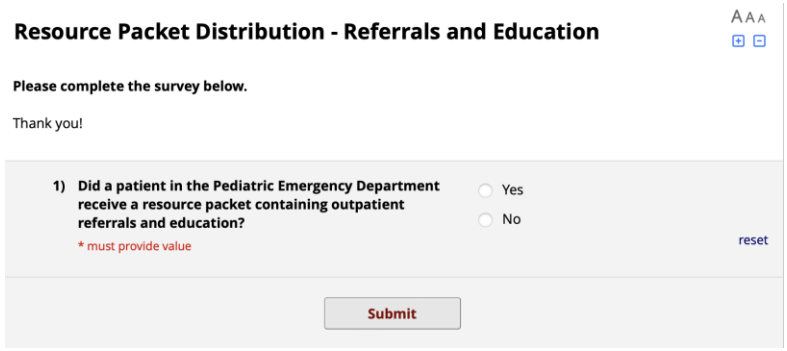
Appendix J

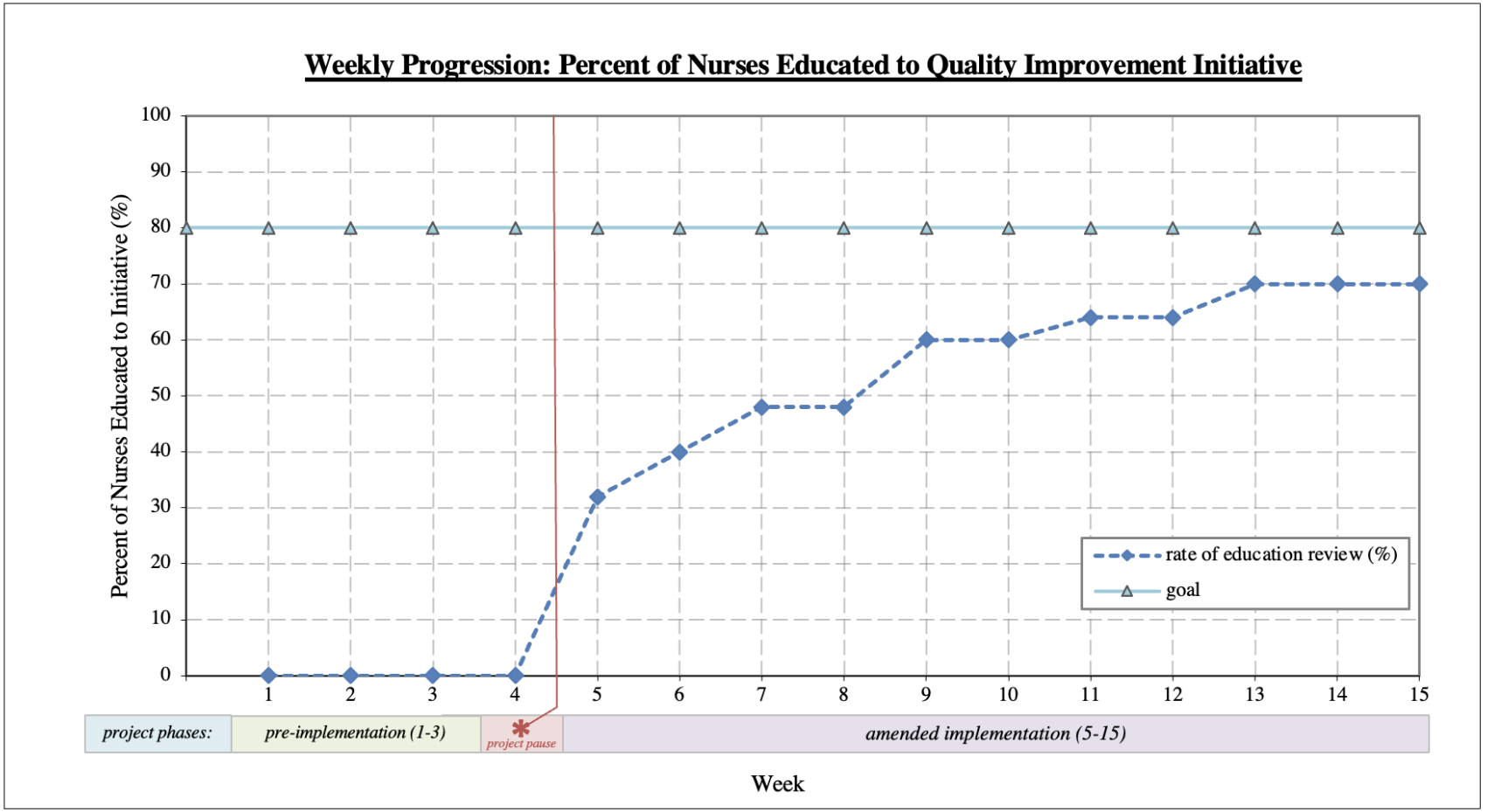
Measurement Tools – Amended QI Initiative (weeks 5-15)



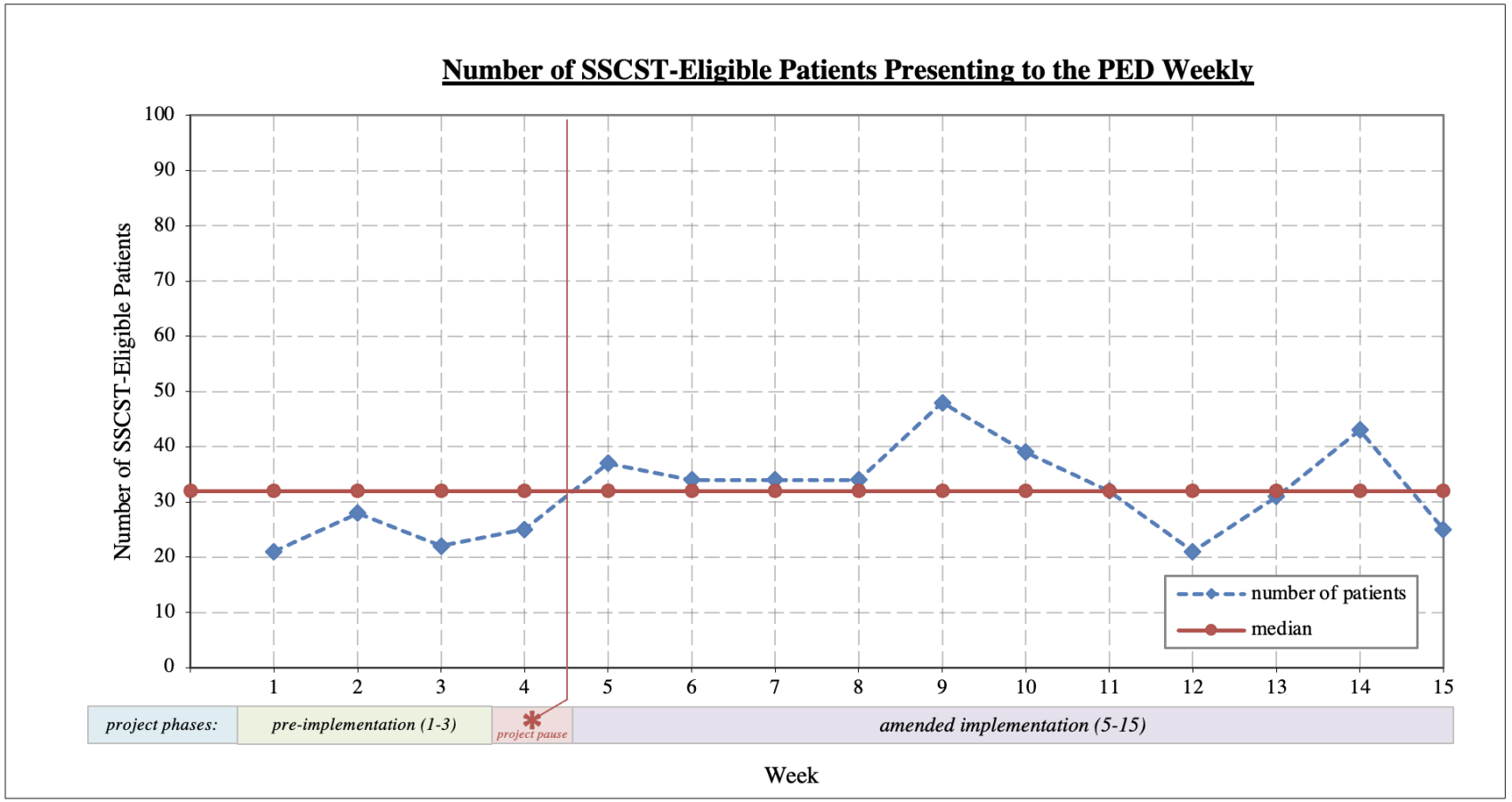


Appendix K

Run Chart: Percent of Nurses Educated to QI Initiative



Run Chart: Weekly Rate of Eligible Patient Presentation in the Pediatric ED



Run Chart: Rate of Resource Distribution to Eligible Patients