

SUPPORTING STATEMENT

Parts A & B

Federal Strategic Action Plan on Services for Victims of Human Trafficking: Enhancing the Health Care System's Response to Human Trafficking

Version: June 24, 2014

Administration for Children and Families (ACF)
HHS/Office on Women's Health (OWH)

Table of Contents

A. JUSTIFICATION.....	3
1. CIRCUMSTANCES THAT MAKE THE COLLECTION OF INFORMATION NECESSARY.....	3
2. PURPOSE AND USE OF INFORMATION.....	5
3. USE OF IMPROVED INFORMATION TECHNOLOGY.....	6
4. EFFORTS TO IDENTIFY DUPLICATION.....	6
5. EFFORTS TO MINIMIZE BURDEN ON SMALL BUSINESSES OR OTHER SMALL ENTITIES.....	6
6. CONSEQUENCES IF INFORMATION COLLECTED LESS FREQUENTLY.....	7
7. SPECIAL CIRCUMSTANCES RELATING TO THE GUIDELINES OF 5 CFR 1320.5.....	7
8A. FEDERAL REGISTER NOTICE.....	7
8B. OUTSIDE CONSULTATIONS.....	7
9. PAYMENTS/GIFTS TO RESPONDENTS.....	8
11. QUESTIONS OF A SENSITIVE NATURE.....	8
12. ESTIMATES OF ANNUALIZED BURDEN HOURS AND COSTS.....	8
13. ESTIMATES OF ANNUALIZED RESPONDENT CAPITAL AND MAINTENANCE COSTS.....	9
14. ESTIMATES OF ANNUALIZED COST TO THE GOVERNMENT.....	9
15. CHANGES IN HOUR BURDEN.....	9
16. TIME SCHEDULE, PUBLICATION AND ANALYSIS PLANS.....	9
17. EXEMPTION FOR DISPLAY OF EXPIRATION DATE.....	9
18. EXCEPTIONS TO CERTIFICATION FOR PAPERWORK REDUCTION ACT SUBMISSIONS.....	9
B. STATISTICAL METHODS.....	10

A. Justification

1. Circumstances That Make the Collection of Information Necessary

In 2013, the U.S. Department of Health and Human Services (HHS) co-chaired an inter-agency process with the Departments of Justice and Homeland Security to create the first Federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States (2013-2017). This Plan addresses the needs for the implementation of coordinated, effective, culturally appropriate and trauma informed care for victims of human trafficking. Based on the goals and commitments outlined in the Plan, there is an administrative requirement that necessitates the collection of these data.

As outlined in the Federal Strategic Action Plan, “Unfortunately, too many people in the United States have either never heard of human trafficking or believe it is a crime that only occurs in foreign countries. Proactive efforts by government and nongovernmental entities to identify victims is critically important because the pervasive use of coercion, and the exploitation of victims’ fears by perpetrators, leads few victims to seek assistance independently, either from law enforcement or service providers. Even when victims are identified, many first responders, including law enforcement and victim service providers at the federal, state, territorial, tribal, and local levels, remain unfamiliar with the range of services available to victims. Public outreach to expand general awareness, and targeted training and technical assistance for allied professionals likely to encounter victims of human trafficking, is a crucial aspect of victim identification and coordinated service delivery. Improved understanding of human trafficking will allow individuals to identify victims and to provide them with referrals for the comprehensive array of services available to trafficking victims. To reach this goal, federal actions fall under two objectives:

OBJECTIVE 5: Increase victim identification through coordinated public outreach and awareness efforts.

OBJECTIVE 6: Build capacity to better identify and serve victims through targeted training and technical assistance.

This is a request, made by the Administration for Children and Families (ACF) and HHS/Office on Women’s Health (OWH), that the Office of Management and Budget (OMB) approve, under the Paperwork Reduction Act of 1995, a clearance for ACF and HHS/OWH to evaluate the trainings for health care providers on human trafficking -- “Stop. Observe. Ask. Respond (SOAR) to Health and Wellness Training”.

HHS formed a technical working group of health care professionals, including physicians, nurses, and community health practitioners, to identify opportunities for increased training and collaboration to better identify and serve victims within targeted health systems. ACF and HHS/OWH will then provide recommendations for training on identifying victims of human trafficking and how to meet their physical and mental health needs.”

The purpose of SOAR is to develop a pilot training project (see Attachment A) that will strengthen the health systems’ response to human trafficking in four key ways:

1. Increase knowledge about human trafficking among health care providers;
2. Build the capacity of health care providers to deliver culturally appropriate and trauma-informed care to victims of human trafficking;

3. Increase the identification of victims of human trafficking; and
4. Increase services to survivors of human trafficking.

To achieve the aforementioned, five (5) sites throughout the country have been chosen to pilot the SOAR to Health and Wellness Training. The learning objectives for the training are for healthcare providers to:

1. Describe the scope, severity, and diversity of human trafficking in the United States;
2. Recognize the common indicators and high risk factors for human trafficking;
3. Use trauma-informed techniques when interviewing a potential victim of human trafficking; and
4. Identify and engage local, state and national service referral options for trafficking victims.

The evaluation will measure immediate outcomes, e.g., from pre-intervention to post-intervention, as well as intermediate outcomes at a 3 month post intervention. The evaluation methodology will include the following key components:

1. A standard pre-test administered 2-3 weeks prior to the training program via an email survey. Since participants will be required to register ahead of time, we will have their names and email addresses prior to the training event and will contact them with information about the training and a link to complete the pre-test. Up to three e-mail reminders will be sent to ensure that all participants complete the pre-test before the training.
2. A post-test at the end of the training program.
3. A 3-month follow-up e-mail survey with ALL participants. A modified pre-/post-test instrument will be emailed to all training participants 3 months after the training to assess whether gains in knowledge and skills or shifts in attitudes have been maintained and generalized, and whether the participants have changed their practice behavior as a result of the training. All participants will be told prior to and during the workshop that we will follow-up with them after four months, and we will obtain significant locator information so we can ensure contact at the 3-month mark. This locator information will include not only work-related data (address, telephone, email, etc.), but also their secondary or private email addresses, cell phones, and names of colleagues who will “always know how to contact them”.
4. A brief (15-20 minutes) 3-month phone interview with a subsample of participants. A second random subsample of participants will be selected and these individuals will be invited to participate in a follow-up phone call to get more specific qualitative data about changes in practice behaviors as a result of the training. The discussion will center on changes in their practice behaviors related to human trafficking since the workshop, number of victims they have identified and what the disposition of these cases was, and a sharing of lessons learned and challenges encountered. The subsample will be 20% of the participants based on the target of 300 provider participants. This represents 60 individuals, which is the sample size considered sufficient to achieve saturation in qualitative research.

This pilot project is being conducted by HHS through a contract with Urban Strategies (HHSP233201300044C).

2. Purpose and Use of Information

The data collected with these evaluation instruments (see Attachment B) under this clearance will allow ACF and HHS/OWH to assess the following domains:

1. Increases in knowledge about human trafficking:
 - a. Definition of human trafficking and types of human trafficking
 - b. Laws that stipulate how to handle suspected cases of human trafficking.
 - c. Populations/subgroups that are more likely to be victims of human trafficking.
 - d. Geographic regions in the U.S. where the likelihood of encountering victims of human trafficking is higher.
 - e. Types of medical conditions victims of various types of human trafficking are likely to present with.
 - f. Signs and symptoms of human trafficking.
 - g. Agencies to collaborate with in delivering services to victims of human trafficking.
 - h. Elements of culturally competent service provision.
2. Increases in skills to work with victims of human trafficking:
 - a. Assessment skills (e.g., what questions to ask and how to ask them).
 - b. Referral and navigation skills (e.g., what legal agencies, social services, etc. to tap into, how to make the referrals, and how to ensure that the victim follows through with the referrals).
 - c. Cultural competency skills (e.g., how a provider can use the knowledge he/she might have about the cultural values, practices, or beliefs of a client who is a victim of human trafficking to more effectively provide services to that client).
 - d. Trauma-focused/trauma-informed skills (e.g., how a provider can use knowledge of trauma and its aftermath to more effectively serve clients who are victims of human trafficking).
3. Measuring changes in the attitudes of healthcare providers about human trafficking and human trafficking victims:
 - a. Challenging biases or stereotypes about who the victims of human trafficking are (e.g., “it only happens to folks who are illegal” or “only women are trafficked”).
4. Measuring intention to change practice behaviors regarding human trafficking and human trafficking victims.
 - a. How often provider thought about human trafficking (e.g., “this person might be a victim of human trafficking”) before training, to how likely they are to proactively think about it after the training.
 - b. How likely provider is to actually act on his/her suspicion that the client might be a victim of human trafficking, rather than assuming a stance of “not my problem, let somebody else deal with it”.
 - c. How likely the provider is to return to their practice setting and continue to inform him/herself and colleagues about human trafficking (e.g., updated a referral list, sharing what they have learned with colleagues through an in-service event,

inviting other local legal or social service providers to come and present on the topic at their practice site, etc.).

5. Measuring actual changes in practice behaviors regarding human trafficking and human trafficking victims.
 - a. At the 3-month follow-up, how many in-service events on the topic have been held in provider's practice setting?
 - b. How many new agencies have been added to the referral list (increases in referral networks)?
 - c. How proactively has the provider been in looking for signs and symptoms of human trafficking?
 - d. Increasing the identification of victims of human trafficking: How many victims of human trafficking has the provider identified since the training? How many had he/she identified in the 3 months before the training?
 - e. How many calls has the provider made to a human trafficking hotline in the 3-months since the training? How many had he/she made in the 3 months before the training?
6. Customer Satisfaction and Feasibility of Scale-Up Efforts. Additionally, since this is a pilot project, scale-up efforts will depend on how well the intervention is received by providers. Healthcare providers can be a challenging group to train due to their time constraints and their unstated reluctance to be trained by individuals who are not medical providers themselves. As such, we will measure some of the following domains as well:
 - a. Overall satisfaction with the training (e.g., length, content, audiovisual aids, facilitators, etc.).
 - b. Suggested changes to the content, gaps in the curriculum, areas they wish we had covered in more depth.
 - c. Likelihood to recommend the training to a colleague.

3. Use of Improved Information Technology

E-mail will be used, when possible, to send reminders and other communications to participants. The majority of the survey questions will be closed-ended; however, there will be open-ended questions to allow for in-depth exploration of the particular subject matter. Electronic submission of all responses is not a viable option.

4. Efforts to Identify Duplication

Every effort has been made to avoid duplication of data collection efforts. The training was prepared by Urban Strategies in conjunction with ACF, HHS/OWH, and the SOAR to Health and Wellness Technical Working Group, along with the review of research and data in the private- and public sectors. The information collection will not duplicate information that is already available.

5. Efforts to Minimize Burden on Small Businesses or Other Small Entities

Data will not be collected from small businesses. Participation in the training and evaluation phase is voluntary. ACF and HHS/OWH have designed the study to minimize the impact of the training and evaluation process.

6. Consequences if Information Collected Less Frequently

The proposed data collection activities involves a pre-test, post-test, and potentially two (2) follow-ups three months post-training with no repetition of data collection planned after the Pilot Program at the four locations. Any less frequent response would not yield useful data for program planning and scale-up efforts.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request is consistent with the general information collection guidelines of 5 CFR 1320.5(d) (2). No special circumstances apply.

8A. Federal Register Notice

As required by 5CFR 1320.8(d), a notice of this proposed data collection appeared in the *Federal Register*, Vol. 79, No. 52, pg. 15129 on March 18, 2014 (see Attachment C), with a specified 60-day period for comment ending May 17, 2014. There were no public comments.

8B. Outside Consultations

The design of this study has proceeded through many stages, which involved outside consultation and expert input from the SOAR to Health and Wellness Technical Working Group, Urban Strategies, and the University of Houston. The names and affiliations of participants are listed below:

Dr. Susie Baldwin
Chief of Health Assessment Unit
Los Angeles County Department

Dr. Jeffrey Barrows, Obstetrician/Gynecologist
Christian Medical Association
VP Education and Advocacy for Abolition International

Lisa Brunner
Program Specialist
National Indigenous Women's Resource Center

Dr. Kimberly S.G. Chang
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Dr. Dominique Roe-Sepowitz
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 American Nurses Assoc/Ctr. for Ethics & Human Rights

Brian Willis
 Director
 Global Health Promise

Dr. Luis R. Torres
 Assistant Professor/Lead Evaluator
 University of Houston

Maralee Gutierrez Cruz
 Project Director/Director of Global Initiatives
 Urban Strategies

9. Payments/Gifts to Respondents

ACF and HHS/OWH do not plan to offer remuneration.

10. Assurance of Confidentiality

Individuals and organizations will be assured of the confidentiality of their replies under Section 944(c) of the Public Health Service Act, 42 USC 299c-3(c). ACF and HHS/OWH will collect the respondent’s name, organizational affiliation, organizational phone number, and role. This information will be used for participant tracking purposes, for clarification call backs, and follow-up. All respondents included in the study will be informed that the information they provide will be used only for the purpose of this research. Individuals will not be cited as sources of information in prepared reports.

11. Questions of a Sensitive Nature

The questions asked in the instruments largely do not involve questions of a sensitive nature.

12. Estimates of Annualized Burden Hours and Costs

The target audience for training and evaluation will be 300 health care providers from hospitals, clinics, and private health practices. The health care providers will be from federal, state/territorial, and local health departments, the Veterans’ Administration, professional associations, and tribal institutions. Exhibit 1 shows the estimated burden hours for this pilot project. The total burden is estimated to be 984 hours. Exhibit 2 shows the estimated cost burden associated with the respondents’ time to participate in the pilot test. The total cost burden is estimated to be \$60,585.

Exhibit 1

Instrument	Estimated # of Respondents	Estimated # of Responses per Respondent	Avg Burden Hrs Per Response	Estimated Total Annual Burden Hrs Requested
Training	300	1	2.0	600.00
Pre-training	300	1	.40	120.00
Post-training	300	1	.40	120.00
Email Follow-up	300	1	.40	120.00
Telephone Follow-up	60	1	.40	24.00
TOTAL HRS.				984.00

Exhibit 2

Study	# of Respondents	Total Burden Hrs.	Avg Hourly Wage Rate*	Total Cost Burden
SOAR	300	984	\$61.57	\$60,585

*The hourly wage for the participants is based upon a mean hourly wages for Registered Nurses (\$33.13) and Physicians and Surgeons/All Other (\$90.00). from the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment and Wages (29-0000 – Healthcare Practitioners and Technical Occupations), May 2013 (http://www.bls.gov/oes/current/oes_stru.htm).

13. Estimates of Annualized Respondent Capital and Maintenance Costs

There are no direct costs to respondents other than their time to participate in the study. There will be no capital, operating, or maintenance costs to the respondent.

14. Estimates of Annualized Cost to the Government

The 15 month contract estimated cost to the federal government for the assessment of stakeholders and resources, development of training, training implementation, and program evaluation for this study is \$441,550. Of that total, approximately \$136,680 will be for training execution and \$89,945 will be for program evaluation. The period of performance for the project is September 30, 2013 through December 31, 2014. Data collection will occur between July and September 2014.

15. Changes in Hour Burden

This is a new collection of information.

16. Time Schedule, Publication and Analysis Plans

The anticipated schedule for this project is shown in Exhibit 3. Once clearance from OMB is obtained, ACF and HHS/OWH will finalize the participant recruiting, training site schedule, and evaluation activities.

Exhibit 3

Activity	Estimated Timeline
Design Training/Instruments	March – June 2014
Recruit Sites/Participants	April – June 2014
Training Phase	July – September 2014
Evaluation Phase	July – December 2014
Analyze Results	September – December 2014
Submit Final & Evaluation Report	December 2014

Publication

Program results will be used internally by HHS to fine-tune the training and program priorities in an effort to launch this training nationally. Report, articles, and presentations will be developed, and distributed as appropriate to share findings with other federal agencies and the public.

Analysis Plan

Data analyses will examine *changes* in knowledge and attitudes through change scores from pre-test to post-test to 3-month follow-up using a repeated measures approach. The pre/post/follow-up instrument has items that measure knowledge and attitudes on a 5-point Likert scale. We will compute a “knowledge” subscale and an “attitudes” subscale, and examine change in scores across the three points in time. Intention to change behavior and actual changes in behavior will be examined with qualitative, open-ended items in the post-test, the 3-month follow-up, and a brief qualitative interview administered to a sub-sample of participants. Customer satisfaction items will be examined at post-test with standard items (see Appendix for sample evaluation questions). Evaluation analysis plans developed by Urban Strategies will be reviewed by HHS.

17. Exemption for Display of Expiration Date

ACF and HHS/OWH will not seek this exemption. All instruments for SOAR will display the OMB control number and expiration date.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

No exceptions are necessary for this information collection.

B. Statistical Methods

Standard statistical procedures will be used to determine knowledge and behavior changes from the pre, to post, to follow time periods.

There will be a random selection from a subsample of participants to complete a telephone interview. There is no experimental vs. control group.

Participants in the training program will be either self-selected or referred to the program by our partner agencies in the various sites. There will be a series of training programs held at various locations, and health providers will attend. All participants enrolled in the program will receive a standard pre-test via email about a week prior to the training (see evaluation form), where most items are answered on a 5-point Likert scale. A slightly modified version will be administered at the conclusion of the training, and again at 3-months follow-up. There will also be a qualitative interview conducted at 3-months follow-up with a subsample of participants randomly chosen from those who attended the training.

Estimation Procedure

Univariate descriptive statistics will include frequencies, cross-tabulations, means, and standard deviations which will provide an overview of the data and characteristics of the participants in the study. Bivariate statistics will include correlations, chi-squares, and t tests to examine relationships between relevant variables. Multivariate statistics will include analyses of variance and multiple regression to build models that might predict successful training elements. This analytic approach will allow us to make sense of the data and to explore whether patterns of responses differ by institution or participant characteristics and to measure changes in knowledge, skills, attitudes, and intention to change practice behaviors regarding human trafficking & human trafficking victims. **The open-ended responses** will be reviewed to develop a set of coding bins into which the data can be usefully categorized. The coded data will then be analyzed to see what patterns emerge and the extent to which we perceive common themes across participants and the trainings. If feasible, we will conduct subgroup analyses to examine whether participants' perceived outcomes vary by location, personal characteristics, e.g., profession or discipline.