Principles for Safe Implementation of ICD Codes for Human Trafficking

Jordan Greenbaum, Ashley Garrett, Katherine Chon, Matthew Bishop, Jordi Luke, and Hanni Stoklosa

Keywords: Electronic Health Records, ICD, Human Trafficking, Confidentiality

Abstract: Human trafficking is associated with a variety of adverse health and mental health consequences, which should be accurately addressed and documented in electronic health records.

Introduction

Human trafficking (HT) involves forced labor exploitation of adults or children, forced commercial sexual exploitation of an adult, or the commercial sexual exploitation of a child.[1] Global studies demonstrate serious health conditions associated with trafficking.[2] While significant barriers to accessing health care and disclosing victimization exist,[3] some trafficked persons seek medical and mental health treatment and their abuse remains undocumented.[4]

Accurate electronic health record (EHR) documentation of HT is critical for understanding, providing and improving patient care. In addition, it allows researchers to identify, characterize, and track health and mental health adversities associated with exploitation.[5] EHR data have been effectively mined to improve patient quality of life and prevent future abuse in other areas, including intimate partner and youth violence.[6] To conduct effective quantitative research, investigators must be able to identify trafficked patients within the health system. This may be done through use of new human trafficking diagnostic codes from the International Classification of Diseases (ICD).[7]

Jordan Greenbaum, M.D., *is the medical director of the International Centre for Missing and Exploited Children and the medical director of the Institute on Healthcare and Human Trafficking at the Stephanie V. Blank Center for Safe and Healthy Children at Children's Healthcare of Atlanta, in Atlanta, Georgia. Her medical degree is from Yale School of Medicine, New Haven, CT.* **Ashley Garrett, M.P.A.,** *is the director of the National Human Trafficking Training and Technical Assistance Center in Washington, DC. Her M.P.A. is from Middlebury Institute of International Studies at Monterey, CA.* **Katherine Chon, M.P.A.,** *is the founding director of the Office on Trafficking in Persons (OTIP) and senior advisor on human trafficking at the U.S. Department of Health and Human Services in Washington, DC. She is the federal executive officer of the National Advisory Committee on the Sex Trafficking of Children and Youth in the U.S. Her M.P.A. is from Harvard University Kennedy School of Government, Boston, MA.* **Matthew Bishop** *is President & CEO of Open City Labs in Ithaca, NY, a Referral and Form Management platform that connects patients to clinical care, social services and government programs that improve health by addressing both clinical and social needs. He is a member of two national committees developing standards for closed loop referral (Office of National Coordinator for Health IT's 360x) and social risk factors (HL7 Accelerator GRAVITY Project).* **Jordi Luke M.A.Ec.,** *is the Director of the Program Alignment and Partner Engagement Group (PAPEG) at the Centers for Medicare & Medicaid Services, Office of Minority Health (CMS OMH) in Woodlawn, MD. Luke leads the CMS Equity Plan for Improving Quality in Medicare and the Minority Research Grant Program. His degree is from Boston University in Boston, MA.* **Hanni Stoklosa, M.D., M.P.H.,** *is the Executive Director of HEAL Trafficking, in Los Angeles, CA, and a physician in the Department of Emergency Medicine at Brigham and Women's Hospital (BWH), with appointments at Harvard Medical School and the Harvard Humanitarian Initiative in Boston, MA. Her M.D. degree is from Tufts University School of Medicine in Boston, MA, and her M.P.H. is from Harvard T.H. Chan School of Public Health in Boston, MA.*

Article updated on April 25, 2023.

The Journal of Law, Medicine & Ethics, 49 (2021): 285-289. © 2021 The Author(s)
DOI: https://doi.org/10.1017/jme.2021.40

https://doi.org/10.1017/jme.2021.40 Published online by Cambridge University Press

Challenges in Documentation and Use of ICD Codes

Challenges in implementing ICD codes for HT fall into the following categories: patient concerns, clinical practice, and organizational adoption.[8] Many of these challenges are mirrored in concerns around documentation of sensitive information in other vulnerable populations (e.g. HIV+ patients, victims of sexual assault or domestic violence).[9] These challenges include:

Patient Concerns of

- Potential bias/discrimination by staff who view ICD codes and other sensitive information.
- Possible violations of confidentiality among healthcare staff and others with access to patient information.
- Possible immigration repercussions (e.g. arrest and deportation).
- Physical and psychological danger if a trafficker gains access to the EHR/Patient Portal.
- Disclosing trafficking experiences.

Clinical Practice

- Many providers lack
  - an understanding of HT
  - experience in the trauma-informed, culturally-responsive approach to exploited patients
  - knowledge of ICD Codes on HT
  - time for screening and assessment of potential HT
- Providers may fear negative impacts related to patient safety, privacy, and confidentiality if a patient is flagged as "trafficked/exploited," while recognizing information can support continuity of care.
- Difficulties in "masking" sensitive data within the EHR, as well as accessing and releasing "masked" information when legally required.
- US requirement that information to determine HT ICD codes is restricted to that which is documented by the health care practitioner legally accountable for establishing the patient's diagnosis, which may cause valuable information from other staff to be excluded from consideration.

Organizational Adoption

- Lack of
  - organizational policies and procedures on how to record and protect sensitive data.
  - reimbursement and time for providers and coders to use HT codes beyond those describing basic physical conditions related to HT.

Principles in the Development of Safe Strategies for ICD Implementation

To meet the challenges inherent in EHR documentation of HT and all other forms of violence, several principles for safe implementation must be considered. These include the following:

Challenges in implementing ICD codes for HT fall into the following categories: patient concerns, clinical practice, and organizational adoption. Many of these challenges are mirrored in concerns around documentation of sensitive information in other vulnerable populations (e.g. HIV+ patients, victims of sexual assault or domestic violence).

1. Patients must be empowered to participate in decisions about accessibility of sensitive information in their EHR, including ICD codes. They need clear, culturally-responsive and linguistically appropriate counseling about EHR documentation, differential access to records, and use of ICD codes. They should be encouraged to ask questions and voice their opinions.
2. Input from survivors of HT, as well as professionals internal and external to the health organization is critical to developing patient-centered, rights-based[10] and trauma-informed strategies for EHR documentation.
3. Strategies for safeguarding sensitive EHR information should be monitored and evaluated continuously.

Safe Strategies for Implementation of ICD Codes Related to Trafficked Patients

The following strategies are based on prior efforts by experts working with other vulnerable populations[11] and multidisciplinary expertise shared at a convening hosted at the Department of Health and Human Services in Washington, DC in December 2019. The latter involved national experts from government agencies, anti-trafficking non-profit organizations, the health

The Journal of Law, Medicine & Ethics, 49 (2021): 285-289. © 2021 The Author(s)

https://doi.org/10.1017/jme.2021.40 Published online by Cambridge University Press

sector (clinicians, coding experts, administrators), and information technology.[12]

Staff and Organizational Capacity Building

1. Develop a HT response plan for the organization, providing for annual staff training; protocols articulating roles and responsibilities for front line, management, and administrative staff; strategies for community engagement, and a continuous quality improvement plan.
2. Train HCPs on labor and sex trafficking, as well as the trauma-informed, culturally-responsive and linguistically appropriate response to suspected exploitation. Online training for HCPs is available through the Office on Trafficking in Persons (https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training). Consider incorporating electronic prompts or clinical reminders within the EHR, which some studies have identified as resulting in increased screening for intimate partner violence, sexual assault, and other health issues.[13]
3. Train all professionals creating or accessing medical records about confidentiality policies and practices.
4. Train healthcare professionals and coders on the new ICD codes for HT and on the specific organizational practices to mask sensitive information in the EHR.
5. Train clinicians how to discuss with patients the confidentiality measures included in EHR documentation and use of ICD codes to promote informed consent by patients regarding management of sensitive information.

Clinical Practice

1. Routinely inform patients of the confidentiality measures included in EHR documentation for sensitive information, as well as who may have limited access and under what circumstances. Engage the patient in the discussion and accommodate reasonable requests related to how documented information may be used or shared (within requirements of the law, concerns of patient safety and health, and public health considerations). In the case of children, patient involvement and consent regarding documentation of sensitive information should be sought as developmentally appropriate and consistent with applicable state law. Mandatory reporting laws require clinicians to contact authorities for suspected child sex trafficking,[14] and the limits of confidentiality associated with these laws should be reviewed with the child prior to discussing sensitive issues. Although the patient does not have a choice in the decision to report, the provider should explain the reasons for reporting (legal obligation, concern for patient safety), listen to the child's worries and concerns about the report, and work to minimize any potential harm that may result from reporting (for example, if the child fears retaliation by the trafficker, the clinician should make sure police and child protective services are aware of the concern and there is a safety plan in place). Further, the child should be encouraged to help determine the way the report is made (for example, whether the clinician makes the call to authorities privately, or in the presence of the child, or whether the child and clinician together speak with authorities).

   Additional considerations may be required in instances of suspected or confirmed forced labor or sexual exploitation of children perpetrated by a parent or guardian. Involvement of guardians in care decisions and disclosure of health information to guardians absent informed consent of the minor may be limited by applicable law and providers may be permitted to refuse guardians otherwise entitled to access to sensitive information to protect the safety and well-being of their patient.

In some states, there are mandatory reporting laws regarding adults who have experienced inflicted injury and/or human trafficking,[15] so if such laws are relevant in the care of a trafficked patient, the clinician should review the reporting procedure with the patient and answer questions. While the patient cannot choose whether or not the report is made and documented in the health record, they can and should, have input into documentation of other sensitive information in the health record (for example, substance misuse, details of trafficking experiences).

2. Implement a zero-tolerance policy for staff explicit bias, stigmatization, or discrimination against patients.[16] Educate staff on implicit bias, as well as codes of conduct and implement a system whereby staff, patients or visitors can safely report bias/discrimination experienced or witnessed in the healthcare setting.

Infrastructure Development

1. Develop facile EHR systems that allow differential access to sensitive information, weighing patient confidentiality with the need to guide continuing health care. Selective "masking" of sensitive information may allow the clinician to block visibility of all or portions of clinical notes, or items

The Journal of Law, Medicine & Ethics, 49 (2021): 285-289. © 2021 The Author(s)
https://doi.org/10.1017/jme.2021.40 Published online by Cambridge University Press

on problem lists. Some designated aspects of the EHR may have default settings that automatically limit viewing access.[17] For example, a health facility may make a policy decision to omit sensitive ICD codes from discharge paperwork and online patient portals. Important in this strategy to differentially mask sensitive information is the ability of the provider and the patient to alter accessibility, and override default privacy settings.[18]

Working with government and third-party payors, policies may allow ICD codes to be omitted from EOB and billing statements or to be listed without descriptors. Clear policies must be in place to ensure that all appropriate documentation is released in response to subpoenas and court orders.

2. Create or further develop national clinical and data standards and health facility policies for EHR data protection, consent, and provenance to share practices. Clearly define the: 1) types of information that may be hidden; 2) patient context (e.g. patient is at risk of suicide); 3) persons allowed access to masked information, 4) process by which that information may be accessed; 5) purposes for which the data can be collected and used; 6) process for correcting data that has been incorrectly recorded; and 7) the process for modifying accessibility to sensitive information.

Policies and procedures should comply with all applicable laws and guidance on privacy and disclosure of sensitive patient information. Legal requirements surrounding mandated reporting laws, patient consent, and subpoenaed records, including state laws that may provide confidentiality protections to victims of HT must be addressed.[19]

Further, to the extent that applicable law or policy limits a provider's ability to implement effective policies and procedures, multidisciplinary stakeholders should collaborate to develop the applicable statutory, regulatory, and subregulatory framework. A multidisciplinary group includes (but is not limited to) survivors of HT, medical, nursing and mental health clinicians, social workers, risk management specialists, billing and coding experts, insurance representatives, health information management and privacy experts, EHR analysts, victim advocates, prosecutors and defense attorneys, and relevant government agency representatives.

Conclusion

Documentation of sensitive patient information in the EHR, including ICD codes for HT, carries major benefits, but introduces the potential for risks to patient privacy and safety. Health professionals and administrators must make every effort to anticipate and minimize unintended adverse consequences. Ensuring adequate protection of patient privacy and confidentiality can be achieved by

- Taking disciplined and consistent steps to maintain a secure EHR,
- Implementing and overseeing specific policies describing data protection, consistant with the 21st Century Cures Act and other policy and legislation, create or further develop national clinical and data standards and health facility policies for EHR data protection, consent, and provenance to share practices,
- Providing adequate staff training regarding management of sensitive information, and
- Facilitating open conversations between provider and patient about how information is documented in the EHR and who is granted access.

To promote safe documentation principles, facilities should assess existing policies and procedures to operationalize best practices specific to the needs of trafficked patients. Relevant law should be further developed, where necessary, with input from multidisciplinary stakeholders, including HT survivors.[20] Much can be learned from work accomplished by those caring for other vulnerable populations, and from multidisciplinary collaboration among experts from all fields related to EHR and human trafficking.

Acknowledgements

The authors would like to acknowledge Elizabeth Pfenning, Claire Castles, and Elise Culliton for their generous time and expertise.

Note

The authors have no conflicts to declare.

References

1. United Nations, *Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime* (2000), *available at* <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtocolTraffickingInPersons.aspx> (last visited May 10, 2020).
2. L. Kiss, N.S. Pocock, V. Naisanguansri, S. Suos, B. Dickson, T. Doan, J. Koehler, K. Sirisup, N. Pongrungsee, N. Van Anh, R. Borland, P. Dhavan, and C. Zimmerman, "Health of Men, Women, and Children in Post-Trafficking Services in Cambodia, Thailand, and Vietnam: An Observational Cross-Sectional Study," *Lancet Global Health* 3 (2015): e154-e161; S. Oram, M. Abas, B. Bick, A. Boyle, R. French, and et al., "Human Trafficking and Health: A Survey of Male and Female Survivors in England," *American Journal of Public Health* 106 (2016): 1073-1078; N.S. Pocock, L.H. Nguyen, D.E. Lucer-Prisno, C. Zimmerman and S. Oram, "Occupational, Physical, Sexual and Mental Health and Violence Among Migrant and Trafficked Commercial Fishers and Seafarers from the Greater Mekong Subregion: A Systematic Review," *Global Health Research and*

The Journal of Law, Medicine & Ethics, 49 (2021): 285-289. © 2021 The Author(s)

https://doi.org/10.1017/jme.2021.40 Published online by Cambridge University Press

Policy 3 (2018): 28-41; L. Ottisova, S. Hemmings, L.M. Howard, C. Zimmerman, and S. Oram, "Prevalence and Risk of Violence and the Mental, Physical and Sexual Health Problems Associated With Human Trafficking: An Updated Systematic Review," *Epidemiology Psychiatry & Science* 25, no. 4 (2016): 317-341, doi:10.1017/S2045796016000135; International Labour Organization, *Towards the Urgent Elimination of Hazardous Child Labour* (2018), *available at* <https://www.ilo.org/ipec/Informationresources/WCMS_IPEC_PUB_30315/lang--en/index.htm> (last visited May 9, 2020); L. Ottisova, P. Smith, and S. Oram, "Psychological Consequences of Human Trafficking: Complex Posttraumatic Stress Disorder in Trafficked Children," *Behavioral Medicine* 44 (2018): 234-241.

3. K. Albright, J. Greenbaum, S. Edwards, and C. Tsai, "Systematic Review of Facilitators of, Barriers to, and Recommendations for Healthcare Services for Child Survivors of Human Trafficking Globally," *Child Abuse & Neglect* 100 (2020): 1-27; S. Armstrong and V.J. Greenbaum, "Using Survivors' Voices to Guide the Identification and Care of Trafficked Persons by U.S. Health Care Professionals: A Systematic Review," *Advances in Emergency Nursing Journal* 41 (2019): 244-260.
4. S.H. Katsanis, E. Huang, A. Young, V. Grant, E. Warner, and S. Larson, "Caring for Trafficked and Unidentified Patients in the EHR Shadows: Shining a Light by Sharing the Data," *PLoS ONE* 14, no. 3 (2019): e0213766, *available at* <https://doi.org/10.1371/journal.pone.0213766> (last visited April 12, 2021).
5. See Ottisova, *supra* note 2; M. Cary, S. Oram, L.M. Howard, K. Trevillion, and S. Byford, "Human Trafficking and Severe Mental Illness: An Economic Analysis of Survivors' Use of Psychiatric Services," *BMC Health Services Research* 16 (2016): 284-290.
6. G. Karakurt, V. Patel, K. Whiting, and M. Koyuturk, "Mining Electronic Health Records Data: Domestic Violence and Adverse Effects," *Journal of Family Violence* 32 (2017): 79-87; E. Miller, B. McCaw, B.L. Humphreys, and C. Mitchell, "Integrating Intimate Partner Violence Assessment and Intervention Into Healthcare in the United States: A Systems Approach," *Journal of Women's Health* 24 (2015): 92-99; E. Sigel, S.B. Harpin and G. Tung, "Increasing Documentation and Referral for Youth at Risk for Violence Through the Primary Health Care Setting," *Clinical Pediatrics* 54 (2015): 451-457.
7. American Hospital Association, "Factsheet: ICD-10-CM Coding for Human Trafficking" (2018) *available at* <https://www.aha.org/factsheet/2018-factsheet-icd-10-coding-human-trafficking> (last visited on May 2, 2020).
8. U.S. Department of Health and Human Services, Office on Trafficking in Persons, International Centre for Missing and Exploited Children and HEAL Trafficking, "Human Trafficking ICD Code Convening — Identifying Electronic Health Record Recommendations to Improve Patient Safety and Clinical Care for Trafficked Persons. Dec 5, 2019 . Washington, D.C.,"
9. W.J. Rudman, "Coding and Documentation of Domestic Violence," Produced by Family Violence Prevention Fund (2000), *available at* <https://www.futureswithoutviolence.org/userfiles/file/HealthCare/codingpaper.pdf> (last visited on May 12, 2020); J. Drinkwater, J. Stanley, E. Szilassy, C. Larkins, M. Hester, G. Feder, "Juggling Confidentiality and Safety: A Qualitative Study of How General Practice Clinicians Document Domestic Violence in Families With Children," *British Journal General Practice* 67 (2017): 3437-3444.
10. M. A. Rothstein, "The Hippocratic Bargain and Health Information Technology," *Journal of Law, Medicine & Ethics* 38, no. 1 (2010): 7-13.
11. See Rudman, *supra* note 9; M. Williams, "Confidentiality of the Medical Records of HIV-Positive Patients in the United Kingdom: A Medicolegal and Ethical Perspective," *Risk Management and Healthcare Policy* 4 (2011): 15-26; L. Lin and B.A. Liang, "HIV and Health Law: Striking a Balance Between Legal Mandates and Medical Ethics," *American Medical Association Journal of Ethics* 7 (2005): 687-692; U.S. Department of Justice and Office for Victims of Crime, "SANE Program Development and Operation Guide," (2020), *available at* <https://www.ovcttac.gov/saneguide/identifying-essential-components-of-a-sane-program/medical-records-maintenance/> (last visited December 25, 2019); U.S. Department of Justice and Office on Violence Against Women, "A National Protocol for Sexual Assault Medical Forensic Examinations," (2013), *available at* <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf> (last visited on April 20, 2020); N. Calman, H.R. Pfister, R. Lesnewski, D. Hauser, and N. Shroff, "Electronic Access to Adolescents' Health Records: Legal, Policy and Practice Implications," (2014), *available at* <https://www.aafp.org/fpm/2015/0300/p11.pdf> (last visited on Feb 2, 2020); A. Anoshiravani, G.L. Gaskin, M.R. Groshek, C. Kuelbs, and C.A. Longhurst, "Special Requirements for Electronic Medical Records in Adolescent Medicine," *Journal of Adolescent Health* 51 (2012): 409-414; Society for Adolescent Health and Medicine, "Recommendations for Electronic Health Record Use for Delivery of Adolescent Health Care: Position Paper," *Journal of Adolescent Health* 54 (2014): 487-490.
12. See U.S. Department of Health and Human Services, *supra* note 8.
13. M.A. Sutherland and M.K. Hutchinson, "Organizational Influences on the Intimate Partner Violence and Sexual Violence Screening Practices of College Health Care Providers," *Research Nursing and Health* 42 (2019): 284-295; R. Onder, J. Spillan, B. Reilley, and J. Leston, "Use of Electronic Clinical Reminders to Increase Preventive Screenings in a Primary Care Setting; Blueprint From a Successful Process in Kodiak, Alaska," (2014), *Journal of Primary Care & Community Health* 5 (2014): 50-54.
14. A. English, "Mandatory Reporting of Human Trafficking: Potential Benefits and Risks of Harm," *AMA Journal of Ethics* 19 (2017): 54-62.
15. H.G. Atkinson, K.J. Curnin, and N.C. Hanson, "U.S. State Laws Addressing Human Trafficking: Education of and Mandatory Reporting by Health Care Providers and Other Professionals," *Journal of Human Trafficking* 2 (2016): 111-138.
16. F. Rubino, R.M. Puhl, D.E. Cummings, R.H. Eckel, D.H. Ryan, J.I. Mechanick, and et al., "Joint International Consensus Statement for Ending Stigma of Obesity," *Nature Medicine* 26 (2020): 485-497; World Health Organization, "Agenda for Zero Discrimination in Healthcare," (2016) *available at* <https://www.who.int/workforcealliance/media/news/2016/agenda-zero-discrimination-healthcare_en.pdf?ua=1> (last visited on May 3, 2020).
17. See Society for Adolescent Health and Medicine, *supra* note 11.
18. See Society for Adolescent Health and Medicine, *supra* note 11.
19. See *e.g.*, Cal. Health & Safety Code § 123115 which requires providers to obtain the consent of minor patients prior to permitting a parent or guardian to access information related to certain services and permits providers to refuse parental access to medical records, even if the parent would otherwise have a right to them, if such access would have a detrimental effect on the provider's relationship with the patient or the minor's physical safety or psychological wellbeing; *See also* Cal. Penal Code § 11166 which requires providers to report any instance of suspected abuse of a child to listed federal and state agencies.
20. B.S. Lee, J. Walker, T. Delbanco, and J.G. Elmore, "Transparent Electronic Health Records and Lagging Laws," *Annals of Internal Medicine* 165 (2016): 219-220.

The Journal of Law, Medicine & Ethics, 49 (2021): 285-289. © 2021 The Author(s)

https://doi.org/10.1017/jme.2021.40 Published online by Cambridge University Press