PurpLE Clinic: A Primary Care Pilot for Survivors of Sexual Violence, Abuse, and Exploitation

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THE INNOVATION

Survivors of sexual violence, abuse, and exploitation—including people who have experienced human trafficking, intimate partner violence, and sexual assault—may avoid health care due to fear of stigmatization and potential re-traumatization in health care settings.[1,2] The PurpLE (Purpose: Listen and Engage) Clinic was a family medicine practice piloted to address these barriers to primary care access for this population.

WHO & WHERE

The clinic was founded and led by a family medicine physician (A.R.) and piloted within a New York City Federally Qualified Health Center (FQHC) from July 2015 to January 2019. During its 3.5 years, the program received nearly 700 referrals from 75 community partners, with 287 patients ultimately connecting for care (62% had repeat visits, ranging from 2 to 43 visits) (**Supplemental Table**). Survivors (and their children) received routine primary care, including reproductive, HIV, LGBTQ+, and preventative health care, regardless of age, documentation, or insurance status. Patients were referred within the FQHC for social work and mental health services.

HOW

Stakeholder feedback, including from incarcerated sex trafficking survivors on Rikers Island,[3,4] was utilized to design PurpLE Clinic's trauma-informed clinical operations and care delivery. Examples included pre- and post-care coordination with referring organizations (**Supplemental Appendix**) and extended appointments (30- to 120-minute visits) to facilitate language interpretation and shared visits with patient advocates from community organizations.

Patients' histories ranged from being in the midst of a trafficking situation or abusive relationship, to being years removed from the experience. Many also had socioeconomic circumstances that further complicated their care, such as unstable housing, intermittent incarceration, financial insecurity, and undocumented status.[5] Based on practice-based experiential learning, the clinic's founder developed the PurpLE Model of Care—incorporating both trauma-informed and social determinant–informed care, and rooted in a violence prevention framework:

Tertiary Prevention

Harm reduction measures for patients in abusive circumstances (eg, contraception access and HIV prevention, injury documentation, safety planning, facilitation of confidential care for survivors who are under their abuser's insurance).

Secondary Prevention

Preventing reentry into abusive conditions among patients who recently exited, by leveraging community partnerships to minimize socioeconomic vulnerabilities (eg, time-sensitive scheduling of pre-employment physicals, writing letters to court supporting alternatives to re-incarceration).

Primary Prevention

Addressing intergenerational trauma for the children of survivor parents (eg, trauma-informed pediatric care, connecting parents with behavioral health and social benefits programs for their children).

Over time, grant funding enabled the clinic's expansion from 1 to 3 days a week, and staffing support from 1 family medicine physician to 2, and a care navigator. Patients were billed per typical FQHC protocol.

LEARNING

PurpLE Clinic identified successful strategies to connect a traditionally hard-to-reach population with primary care. It also highlighted that the sustainability of a specialized trauma-based clinic within an FQHC requires both organizational commitment and broader payment reforms. System-wide trauma-informed–care training, and team-based care involving both primary care and mental health departments, are necessary to longitudinally engage trauma survivors.[5] Because FQHCs are generally beholden to reimbursement structures prioritizing volume and conventional quality metrics, independent grant funding was needed to sustain program features such as extended visit lengths and collaborative care. The FQHC-based pilot ultimately concluded in order to further develop the care model outside of a conventional health care setting. Feasible aspects of the model were adapted into other FQHC initiatives for specialized populations.

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Key words: access to primary care; trauma-informed care; human trafficking; domestic violence; primary health care

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Supplemental materials, including references

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