

09-02

STATEMENT OF POLICY

Expedited Partner Therapy

Policy

The National Association of County and City Health Officials (NACCHO) supports the legalization and utilization of Expedited Partner Therapy (EPT), or Patient Delivered Partner Therapy (PDPT) in states, territories, and jurisdictions where it is not legally permissible or where the legal status of EPT is unclear or ambiguous. EPT or PDPT is the clinical practice of treating the sex partners of patients diagnosed with chlamydia, trichomoniasis, and/or gonorrhea (depending on the state) by providing prescriptions or medications to the patient to take to their partner(s) without that individual also being examined by a healthcare provider. EPT is a harm-reduction strategy which allows for the treatment of sex partners of persons with diagnosed sexually transmitted infections (STIs), who are unable or unlikely to seek treatment, and decreases the chance of reinfection to the patient by their partner(s). EPT is legal in most states but varies by infection and jurisdiction. The strategy has been recommended by the Centers for Disease Control and Prevention (CDC) since 2006.

NACCHO encourages state and local health departments to work with healthcare providers, pharmacists, and policymakers to promote the implementation of EPT by increasing awareness of the practice and providing or developing guidance and educational information regarding its implementation and legality.

NACCHO recommends:

- Implementation of EPT for both chlamydia and gonorrhea be in accordance with the CDC's STD Treatment Guidelines and EPT guidance, which state that EPT should be considered for the treatment of chlamydia and gonorrhea in heterosexual partners when other partner management strategies are impractical or unavailable and whose providers are concerned about partners' access to prompt clinical evaluation and treatment.
- Where it is not already permissible, local health departments should advocate for state laws and/or policies that allow for the provision of packaged oral medications to be provided to the patient for their partner(s) rather than prescriptions as provision of medication increases the likelihood of EPT use.
- Additional research and evaluation to strengthen the evidence base for EPT and to determine the effectiveness of EPT among same-sex partners, particularly men who have sex with men.
- Additional research and evaluation to strengthen the evidence base for EPT for trichomoniasis.

Justification



Chlamydia and gonorrhea present significant public health challenges. In 2019, a total of 1,808,703 chlamydial infections and 616,392 cases of gonorrhea were reported in the United States, representing the first and second most reported notifiable diseases in the country.¹ It is estimated that incidence of these infections is even higher due to under-reporting, since most people are not aware of their symptoms and do not seek testing. As in past years, there were significant disparities in rates of reported STIs. In 2019, over half (55.4%) of reported cases were among adolescents and young adults (aged 15-24). At the same time, 30.6% of all cases of chlamydia, gonorrhea, and syphilis were among non-Hispanic Blacks, even though they represent just about 12.5% of the US population.¹ Optimal partner management for STIs involves bringing the partner(s) of a person with an STI into the clinic for evaluation, counseling, testing, and treatment; however, few health departments or healthcare providers have the resources to do so for gonorrhea and/or chlamydia.² As such, many sex partners of persons with chlamydia or gonorrhea are not treated, which leads to frequent reinfections and further transmission.³ EPT has been demonstrated to reduce healthcare costs by reducing the spread of infections and reinfections.⁴ Studies have shown that patients whose partners received EPT were 20-29% less likely to be reinfected than those who simply told their partners to visit the doctor for treatment.⁵

EPT offers an evidence-based strategy for partner notification and treatment. Studies have shown that compared to standard referral of partners, EPT for chlamydia and gonorrhea significantly reduced persistent or recurrent infections among patients;⁶ lowered rates of reinfection;⁷ and can be a cost-saving partner management strategy.⁸ Making EPT available through public health clinics has demonstrated increased uptake and has the potential to decrease chlamydial and gonococcal infections at the population level.⁸ Moreover, state legislation prohibitive of EPT has been associated with increased chlamydia incidence.⁹ Providing patients with packaged oral medication is the preferred approach because the efficacy of EPT using prescriptions has not been evaluated, obstacles to EPT can exist at the pharmacy level,^{10,11} and many persons (especially adolescents) do not fill the prescriptions provided to them by a sex partner.^{12,13} Medication or prescriptions provided for EPT should be accompanied by educational materials for the partner, including treatment instructions, warnings about taking medications (e.g., if the partner is pregnant or has an allergy to the medication), general health counseling, and a statement advising that partners seek medical evaluation as soon as possible for HIV infection and any symptoms of STIs, particularly pelvic inflammatory disease (PID).

Evidence supporting EPT is based on three U.S. clinical trials involving heterosexual men and women with chlamydia or gonorrhea.^{3,14,15} All three trials reported that more partners were treated when patients were offered EPT. Two reported statistically significant decreases in the rate of reinfection, and one observed a lower risk for persistent or recurrent infection that was statistically nonsignificant. A fourth trial in the United Kingdom did not demonstrate a difference in the risk for reinfection or in the numbers of partners treated between persons offered EPT and those advised to notify their sex partners.¹⁶ U.S. trials and a meta-analysis of EPT revealed that the magnitude of reduction in reinfection of index patients, compared with patient referral, differed according to the STI and the sex of the index patient.^{17,18,19,20} However, across trials, reductions in chlamydia prevalence at follow-up were approximately 20%, and reductions in gonorrhea were approximately 50% at follow-up.²¹

EPT for the treatment of gonorrhea and chlamydia in heterosexual partners has been recommended by the CDC since 2006.^{26, 10} EPT is also supported by professional medical associations, including the American Medical Association,¹¹ American College of Obstetricians and Gynecologists,¹² Society for Adolescent Health and Medicine,²⁷ and American Academy of Family Physicians.¹³ Additionally, EPT is supported by the National Coalition of STD Directors¹⁴ and the American Bar Association, which passed a resolution in 2008 urging the removal of legal barriers to implementing EPT nationally.¹⁵ Existing data indicate that EPT also might have a role in partner management for trichomoniasis; however, no partner management intervention has been reported to be more effective than any other in reducing trichomoniasis reinfection rates.^{22,23} No data support use of EPT in the routine management of patients with syphilis. Considering limited data and potential for other bacterial STIs among MSM partners, shared clinical decision-making regarding EPT is recommended in those cases.^{24,25} This is a modification from the previous STI treatment guidelines which did not recommend EPT for MSM.

Despite the effectiveness of EPT, legal, medical, practical, and administrative barriers can hinder routine use by healthcare providers. According to the CDC, as of April 2021, EPT is “potentially allowable” in 4 states (South Dakota, Kansas, Oklahoma, and Alabama) and the territories of Puerto Rico and Guam and legal in all other states and the District of Columbia.¹⁶ Uncertain legal status and lack of knowledge of legal statutes present significant barriers to the use of EPT, and both healthcare providers and pharmacists require education regarding the method’s legality, utilization, and provision. According to one study, only about half of providers reported ever having prescribed drugs to the partners of patients with chlamydia and only 10 percent said they always did.¹⁷ Though measured infrequently, pharmacists’ knowledge of EPT’s legal status has been shown to be low, potentially impacting medication dispensing.^{18, 31}

Action should be taken to develop specific interpretation of inconsistent or amorphous provisions, establish policies consistent with legal authorization, and incorporate EPT into treatment guidelines. Even where legal, providers may have concerns that it presents a legal liability risk for prescribing or dispensing antibiotics to their patients’ sex partner(s) without a prior examination of those partners.¹⁸ To address these challenges, some states have included language in the law and regulations permitting EPT to protect healthcare providers or pharmacists who dispense EPT in accordance with the law, noting that they shall not be subject to liability or be deemed to have engaged in unprofessional conduct.²⁸ Other challenges to implementation include cost (the cost of the additional medication and reimbursement for time spent implementing EPT); administrative barriers (determining how to record the medication dispensation or prescriptions provided to patients who are not directly under the care of the provider); missed care opportunities for counseling and detection of other STIs, including HIV; and incomplete treatment/noncompliance. Addressing these challenges will require collaboration among health departments, healthcare providers, pharmacists, and policy makers.

Concerns regarding adverse drug effects and antimicrobial resistance have also been raised; however, they are not supported by data. Serious adverse reactions are rare with recommended chlamydia and gonorrhea treatment regimens, and in EPT programs that have monitored adverse events, no drug-related adverse effects or lawsuits arising from this type of care have been documented.²⁷ The risk of serious adverse reactions can be further minimized by accompanying

EPT with clear written instructions and educational information for partners, as well as encouragement to visit a healthcare provider. There is also no evidence that EPT leads to increasing antibiotic resistance at a population level, and research has shown that the risk of not treating a partner outweighs the risk of using EPT to treat gonorrhea.²⁹ Given the growing problem of antibiotic-resistance, the CDC continues to monitor antibiotic resistant gonorrhea through several activities and strategies related to collecting isolates; increasing capacity of national, state, and local STD programs to detect and respond to trends; and developing national recommendations for the public health response to antibiotic-resistant gonorrhea. Despite CDC's recent changes to its gonorrhea treatment recommendations in which a single intramuscular dose of ceftriaxone 500mg is the only CDC-recommended treatment for uncomplicated urogenital, anorectal, and pharyngeal gonorrhea¹, CDC continues to recommend EPT for heterosexuals with gonorrhea for whom health department partner management strategies are impractical or unavailable and whose providers are concerned about the partners' access to prompt clinical evaluation and treatment.³⁰ CDC prefers EPT via injection if possible.³

Treating a patient's sexual partner(s) is crucial to prevent the spread of STI infections and stop the patient from becoming reinfected. Barriers to implementing EPT must be removed and addressed to increase the uptake of EPT and maximize its impact on STI prevention efforts to best position LHDs to tackle STIs in their communities.

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16. Centers for Disease Control and Prevention. (20). Legal status of Expedited Partner Therapy. Atlanta, Georgia: U.S. Department of Health and Human Services. Retrieved on August 26, 2021 from <http://www.cdc.gov/std/ept/legal/default.htm>. *Note that the legal status of EPT depends on several different factors, including existing statutes and regulations, judicial decisions, and prescription requirements, among others. In some cases, while EPT is legally permissible, prescription requirements, for example, may impact how EPT is implemented in practice, thus while a state may be considered to permit EPT, prescription and dispensing might be limited. Additionally, EPT might be restricted to certain STDs or types of partners, though it would still be considered legally permissible. For an alternative explanation of the legal status of EPT, visit the Guttmacher Institute's Partner Treatment for STIs page at <https://www.guttmacher.org/statepolicy/explore/partner-treatment-stis>.*
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Record of Action

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