

09-02

STATEMENT OF POLICY

Expedited Partner Therapy

Policy

The National Association of County and City Health Officials (NACCHO) supports the legalization of Expedited Partner Therapy (EPT), or Patient Delivered Partner Therapy (PDPT) — the clinical practice of treating the sex partners of patients diagnosed with chlamydia and gonorrhea (depending on the state) by providing prescriptions or medications to the patient to take to their partner(s) without first being examined by a healthcare provider — in states, territories, and jurisdictions where it is not legally permissible or where the legal status of EPT is unclear or ambiguous. With this concept in mind, NACCHO recommends:

- Implementation of EPT for both chlamydia and gonorrhea be in accordance with the Centers for Disease Control and Prevention's (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.
- 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.

Additionally, NACCHO encourages state and local health departments to work with healthcare providers, pharmacists, and policy makers 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.

Justification

Chlamydia and gonorrhea present significant public health challenges. In 2016, a total of 1,598,354 chlamydial infections and 468,514 cases of gonorrhea were reported in the United States, representing the first and second most commonly 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. The CDC estimates that 2.86 million chlamydial infections and 820,000 cases of gonorrhea occur annually — more than double what is reported — and that \$850 million is spent annually treating chlamydia and gonorrhea in the United States.^{2,3} EPT has been demonstrated to reduce healthcare costs by reducing the spread of infections and reinfections.⁴



Partner notification to assure treatment of sex partners has been an essential component of prevention and control of bacterial sexually transmitted infections (STIs) since the 1940s.⁵ Standard approaches to partner notification include patient referral and provider referral, though these methods face limitations due to the accuracy of the disclosed partner information, compliance, and staffing resources.⁶ Optimal partner management involves attempting to bring the partner to clinical care for evaluation, counseling, testing, and treatment; however, few health departments or healthcare providers have the resources to do so. As such, many sex partners of persons with chlamydia or gonorrhea are not treated, which leads to frequent reinfections and further transmission.⁷

EPT offers an additional, 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;⁸ lowered rates of reinfection;⁹ and can be a cost-saving partner management strategy.¹⁰ 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.¹⁰ Moreover, state legislation prohibitive of EPT has been associated with increased chlamydia incidence.¹¹

EPT for the treatment of gonorrhea and chlamydia in heterosexual partners has been recommended by the CDC since 2006.^{5, 12} EPT is also supported by professional medical associations, including the American Medical Association,¹³ American College of Obstetricians and Gynecologists,¹⁴ Society for Adolescent Health and Medicine,⁶ and American Academy of Family Physicians.¹⁵ Additionally, EPT is supported by the National Coalition of STD Directors¹⁶ and the American Bar Association, which passed a resolution in 2008 urging the removal of legal barriers to implementing EPT nationally.¹⁷

Despite the effectiveness of EPT, legal, medical, practical, and administrative barriers can hinder routine use by healthcare providers. According to the CDC, as of July 2017, EPT was permissible in 41 states and the District of Columbia; potentially allowable in 7 states and Puerto Rico; and prohibited in 2 states (Kentucky and South Carolina)¹⁸. Uncertain legal status or lack of knowledge of legal statutes presents a significant barrier to the use of EPT, and both healthcare providers and pharmacists require education regarding the method's legality, utilization, and provision. Though measured infrequently, pharmacists' knowledge of EPT's legal status has been shown to be low, potentially impacting medication dispensing.¹⁹

Where EPT is potentially allowable, 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 perceive the practice to be illegal or 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.²⁰ 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.²¹ 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.⁶ 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.²² 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.²³ Despite CDC's recent changes to its gonorrhea treatment recommendations in which ceftriaxone is administered intramuscularly instead of orally, EPT for gonorrhea is still recommended if it is unlikely that a heterosexual partner of a patient infected with gonorrhea will access timely evaluation and treatment.²²

Treating a patient's sexual partner(s) is crucial to prevent the spread of the infection 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 STD prevention efforts.

References

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Record of Action

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