

# Expedited Partner Therapy Toolkit: a response to EPT implementation barriers

George E. Ware & the Region VIII Infertility Prevention Project Partner Services and Treatment Verification Workgroup  
STD/HIV Section, Colorado Department of Public Health and Environment, Denver, CO

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## Colorado Expedited Partner Therapy Survey

A brief telephone survey to identify EPT related practices among STD clinic sites that participate in the Colorado IPP was administered on December 12, 2005. Survey respondents included IPP contacts at the Denver, El Paso, Larimer, Jefferson, and Weld county health departments. Results of the survey are summarized below.

**How often was EPT practiced?** Among the five STD clinics that participate in the Colorado IPP, two did not practice EPT as a partner management strategy. EPT was an occasional or rare practice among the remaining three STD clinics.

**Under what circumstances was EPT practiced?** In one EPT practicing STD clinic, EPT was more often used in treating a partner(s) after a woman was diagnosed with trichomoniasis. When diagnosed, the patient was given medication for her partner. This clinic would treat asymptomatic male partners of women diagnosed with GC/CT who come into the clinic to receive medication without requiring that the partner receive an examination. All female partners of men with GC/CT would be examined before treatment due to the risk of undetected PID. In another EPT practicing clinic, clinicians stated they "try really hard to get partners to come into the clinic." The survey respondent related a rare case in which a partner was treated only after a patient reported that her male partner refused to come to the clinic for treatment. At that point, the nurse practitioner reluctantly wrote a prescription for the partner. In contrast, a nurse practitioner working in a prenatal clinic within this same health department would readily give a prescription for treating partners. However, this was not common practice among the nurse practitioners in the prenatal clinic.

**What were the barriers to EPT?** Barriers to routine practice of EPT included:

- Information regarding the partner was secondhand. The original patient may have no knowledge of a partner's allergy history or if the partner is currently taking other medications.
- Partner treatment cannot be tied to a specific person. One clinic was switching to an electronic system for generating prescriptions. For those prescriptions given to partners, there would be no tie to a patient record number when the partner is not also a patient at the clinic. In another clinic, EPT was problematic because there was no social security number or other identifier available to link the treated partner with the prescribed treatment.
- Clinicians were unsure whether EPT was good medical practice and feared that practicing EPT might result in losing their licenses.
- Clinic directors were often resistant to EPT and needed information about why EPT was desirable and how it should be implemented.
- Clinic staff did not know whether EPT was a practice that was recommended by the state health department.
- EPT was so rarely practiced that clinicians had little experience with this practice.

**What would be needed to make EPT a more routine practice?**

Medical directors needed information about the number of clinics that were practicing EPT, how EPT was being implemented, how EPT should be implemented, and evidence that EPT is good medical practice. Other directors needed to know that EPT was a practice that is supported by the state health department.

Clinicians needed to know that EPT was a practice recommended by their clinic directors. They also needed assurance that EPT was consistent with good medical practice and would not negatively impact their licenses. Clinicians also needed guidance about how EPT would be implemented in their clinic settings.

## Names and affiliations of Region VIII IPP PSTV Workgroup

Colorado Department of Public Health & Environment  
Denver Public Health  
Montana Department of Health & Human Services  
North Dakota Department of Health  
South Dakota Department of Health  
Utah Department of Health  
Wyoming Department of Health



Colorado: George Ware (STD), Kees Rietmeijer, MD (STD)  
Montana: Ellie Hardy (FP), Liz Johnson (FP)  
North Dakota: Char Reitswig (FP)  
South Dakota: Bev Duffel (FP), Dave Morgan (STD)  
Utah: Tim Lane (STD)  
Wyoming: Canyon Hardesty (STD), Greg Welch (STD)  
John Snow Institute: Lindsey Blackwelder, Yvonne Hamby, Ann Loeffler

## Colorado Policy Regarding EPT

Colorado State Board of Medical Examiners Policy  
POLICY NUMBER: 40-10

Title: Appropriateness of Treating Partners of Patients with Sexually Transmitted Infections  
Date Issued: 5/10/01

**Purpose:** To clarify the Colorado Board of Medical Examiners' position concerning the appropriateness of physicians treating the partners of patients with sexually transmitted infections.

**POLICY:** The Board acknowledges the concern and dilemma which occurs when a physician encounters a patient with a sexually transmitted infection, and the partner of the patient does not come to the physician's office. The ideal situation would be that each partner visit his or her primary healthcare provider for treatment. However, the Board recognizes that what is idealistic may not be realistic. There is compelling need for the partner to receive treatment in the form of prescription medications. Treating partners of patients with sexually transmitted infections is generally considered acceptable and desirable if the partner will not seek treatment from his or her primary healthcare provider. The overriding public policy concern must be to treat the infected partner. It must be made clear to the patient that his or her partner must take the medication as prescribed and should follow-up with his or her own healthcare provider. If the partner has any drug allergy or is on any medication, he or she should consult with a healthcare provider before filling the prescription. It is the position of the Colorado Board of Medical Examiners that the public risk of untreated sexually transmitted infection is greater than the risk of complications from prescribing in this less than ideal setting.

## Region VIII Partner Services Survey

**Goal:** Implement feasible, effective, and appropriate practices for partner management.

**Objective:** By October 1, 2006, develop and implement plans to encourage the use of EPT among IPP providers based on results of Region VIII Partner Services survey conducted Dec 2005 – Jan 2006.

- Colorado - 20 Family Planning (FP) clinics; 5 STD clinics
- Montana - 4 FP clinics; 1 community health center
- South Dakota - FP clinics

### Limited EPT (13 clinics practice)

- Will send meds for male partners when a woman has been diagnosed with trichomoniasis.
- Attempts to get partner to come into the clinic have failed.
- Patient refuses to provide information about partners.

### Routine EPT (8 clinics practice)

- As a standard practice, medication or a prescription is given to a patient with the expectation that the patient will give the medication/prescription to their partner.

### Alternative Partner Management Practices

- Require the partner to come into the clinic for treatment.
- Provide the original patient with referral cards.
- Work with DIS to ensure partners are notified and referred for exam/treatment.

### EPT Barriers

- Patient may have no knowledge of partners' allergies or current meds.
- Partner treatment is not tied to a specific individual.
- Partner may not receive meds or adequate information about infection.
- Unsure if EPT is good medical practice.
- Concerns about liability, loss of license to practice.
- No guidance from the state health department that EPT is a recommended practice.
- No standing orders for treatment.
- Health department guidelines that azithromycin should only be used for directly observed therapy.

There is a perception that EPT negatively impacts the ability to stem disease spread when:

- Partners do not receive counseling and educational messages.
- Partners of persons who are infected and treated but not tested will not be notified of exposure.

### Possible EPT Barrier

- Clinics that rarely or never use EPT report that they do "an excellent job of getting partners in for treatment."

## Survey Results and Recommendations

**What is needed to make EPT a routine/standard practice?**

**Medical directors** need information about the number of clinics practicing EPT, how EPT is currently being implemented, how EPT should be implemented, why EPT is good medical practice and that EPT is supported by the state health department.

**Clinicians** need to know that EPT is recommended by their clinical directors, EPT is good medical practice and will not jeopardize their licenses, and need to have guidance about how EPT is implemented in their clinic setting.

**How could EPT be implemented in Region VIII?**

Based on the results of these surveys in each state, the workgroup decided to develop an EPT toolkit for use across Region VIII. The EPT toolkit would be available to medical directors, clinicians, health department staff, and others.

## Region VIII EPT Toolkit Contents

### I. Supporting documentation and research

- Dear Colleague Letter
- CDC STD Treatment Guidelines
- CDC Expedited Partner Therapy in the Management of STDs: Review and Guidance, 2006

### II. Current Rules and Regulations regarding EPT

- Wyoming legislative drafts
- CO Board of Health 2001 policies
- CO Board of Pharmacy 2007 policy
- Documents from CDC website with legislative rules
- Updated EPT rules and regulations for each Region VIII state.

### III. Sample policies and protocols, and successful strategies

- MT, WY, CO-Denver Public Health, Seattle
- Successful strategies will take the form of vignettes describing effective means of implementing EPT (e.g., health care providers providing patients with medications for their partners, prescribing medications in the original patient's name, prescribing medications in the partner's name, or disease interventions specialists delivering medications to a named partner) and also effective means of garnering administrative support for EPT. These will be solicited by states and collated by John Snow Institute staff for review and inclusion approved by the workgroup. Each vignette will include contact information.

### IV. Contact Information

- Include name, state, organization, address, phone, email, and EPT status.

## EPT in the Management of STDs: CDC Guidance, 2006

EPT is at least equivalent to patient referral in preventing persistent or recurrent gonorrhea or chlamydial infection in heterosexual men and women, and in its association with several desirable behavioral outcomes. These conclusions support the following recommendations:

**Gonorrhea and chlamydial infection in women:** EPT can be used to treat partners as an option when other management strategies are impractical or unsuccessful. Symptomatic male partners should be encouraged to seek medical attention, in addition to accepting therapy by EPT, through counseling of the index case, written materials, and/or personal counseling by a pharmacist or other personnel.

**Gonorrhea and chlamydial infection in men:** EPT can be used to treat partners as an option when other management strategies are impractical or unsuccessful. Female recipients of EPT should be strongly encouraged to seek medical attention, in addition to accepting therapy. This should be accomplished through written materials that accompany medication, by counseling of the index case and, when practical, through personal counseling by a pharmacist or other personnel. It is particularly important that female recipients of EPT who have symptoms that suggest acute PID, such as abdominal or pelvic pain, seek medical attention.

**Gonorrhea and chlamydial infection in men who have sex with men:** EPT should not be considered a routine partner management strategy, because data are lacking on the efficacy in this population, and because of a high risk of co-morbidity, especially undiagnosed HIV infection, in partners. EPT should only be used selectively, and with caution, when other partner management strategies are impractical or unsuccessful.

**Women with trichomoniasis:** EPT is not recommended for routine use in the management of women with trichomoniasis, because of a high risk of STD co-morbidity in partners, especially gonorrhea and chlamydial infection. EPT should only be used selectively, and with caution, when other partner management strategies are impractical or unsuccessful.

**Syphilis:** EPT is not recommended for routine use in the management of patients with infectious syphilis.