

Introduction to Region VIII Expedited Partner Therapy (EPT) Toolkit

INTRODUCTION

In light of the recommendations and barriers related to use of EPT, the Region VIII Infertility Prevention Project has prepared this EPT toolkit to assist participating sites and clinicians in exploring whether, how, and when to implement EPT as a partner management strategy.

BACKGROUND

In 2005, the Centers for Disease Control and Prevention received reports of 976,445 chlamydia cases and 339,593 gonorrhea cases that occurred in the U.S.¹ As an important component of reducing the prevalence and impact of these and other STDs, public and private providers have implemented various strategies for managing the partners of patients diagnosed with an STD. Types of partner management include provider referral in which the health department or provider notifies a partner of an STD exposure with or without the assistance of the original patient, and patient referral in which the original patient attempts to ensure his/her partner receives appropriate medical follow-up without assistance from the health department or provider. A limited number of studies suggest that provider referral is more successful in ensuring that exposed partners receive appropriate medical follow-up compared to patient referral. However, the high number of cases and the costs of provider referral make use of this partner management strategy an impractical tool for controlling GC and Ct in many regions of the U.S.

EVIDENCE

As a means to assure that exposed partners are adequately treated, providers in many areas are practicing expedited partner therapy (EPT) by which partners of STD patients are treated without an examination and without counseling messages. Among EPT practices, some providers are utilizing patient-delivered partner therapy (PDPT) in which patients diagnosed with an STD deliver medications to their partners. To encourage more widespread consideration of these partner management options, the CDC published its 2006 guidance report, *Expedited partner management in the treatment of sexually transmitted diseases*.² The guidance summarized evidence based on the results of four randomized controlled trials (RCT) for the efficacy of EPT in preventing recurrent chlamydia and gonorrhea infections after initial treatment and in ensuring that partners are notified and receive treatment. Additionally, the RCT demonstrated that EPT was associated with a decreased likelihood that a patient would have sex with an untreated

¹ Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2005*. Atlanta, GA: US Department of Health and Human Services, November 2006.

² Centers for Disease Control and Prevention. *Expedited partner therapy in the management of sexually transmitted diseases*. Atlanta, GA: US Department of Health and Human Services, 2006.

partner. The following salient findings related to EPT are found within the CDC guidance:

- In one six-city multicenter study, female patients diagnosed with chlamydia that were provided azithromycin to give to their partners were statistically no more likely to have persistent or recurrent chlamydia infections at one month and four month follow-up than were women who were provided a list of clinics where their partners could be examined.
- In Seattle-King County, persistent or recurrent gonorrhea and chlamydia infections were found less often among male and female patients assigned to deliver medications to their partners than among patients assigned to patient referral or provider referral arms of the study. EPT was shown to be more effective at preventing recurrent gonorrhea infections than chlamydia infections.
- In New Orleans, among a subset of 977 men with symptomatic urethritis who were diagnosed with gonorrhea, chlamydia, or both, those assigned to the PDPT arm of the study were significantly less likely to experience a recurrent infection upon follow-up testing.
- PDPT was slightly more costly than patient referral when considering only program costs. However, when factoring in the cost savings from preventing infection sequelae such as PID, EPT was shown to be a cost effective strategy.

The CDC has been joined by the American Medical Association in recommending that EPT be considered and implemented as a partner management strategy.

OPERATIONAL BARRIERS

A number of barriers remain to be addressed in ensuring more widespread and consistent use of EPT. A 2005 survey of various clinical sites in the Region VIII IPP³ identified a number of these barriers including:

- Information regarding the partner is 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 that was in the process of implementing an electronic system for generating prescriptions noted that there would be no tie to a patient record number when the partner was not also a patient at the clinic. In another clinic, EPT was deemed problematic because no social security number or other identifier would be available to link the treated partner with the prescribed treatment.

³ The 2005 EPT survey obtained data from IPP sites located in Colorado, Montana, and South Dakota. The survey was designed to identify how often EPT was being practice, the circumstances when EPT was practiced, barriers to implementing EPT, and what clinics would need to implement EPT as a more standard practice. One community health center, five STD clinics, and over twenty-four family planning clinics provided survey information.

- Clinicians were unsure whether EPT is good medical practice and feared that practicing EPT might result in losing their license to practice.
- EPT was so rarely practiced that clinicians had little experience with its use.
- Clinic directors were described as often being resistant to EPT and in need of information about why EPT is desirable and how it should be implemented.
- Clinics did not know whether EPT was a practice that was recommended by their state health department.

Additional barriers to EPT have also been cited. Similar to situations involving more traditional DIS mediated partner notification, a diagnosed patient may refuse to deliver medications or a prescription to a partner because s/he: 1) does not know or has no locating information for the partner; 2) does not like the partner; or 3) is afraid of the partner. EPT may also be resisted because it is seen as a missed opportunity to test for other STD and to provide counseling messages to an exposed partner. Although the risk of adverse reactions to therapy has been shown to be low, providers may be reluctant to tolerate even a low risk given possible legal and medical ramifications of an adverse event. Additionally, EPT is not feasible in many settings because of operational barriers, including the lack of clarity regarding the legality of practicing EPT in many states.