

09-02

STATEMENT OF POLICY

Expedited Partner Therapy

Policy

The National Association of County and City Health Officials (NACCHO) supports:

- Legalization of Expedited Partner Therapy (EPT)- the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without first being examined by a health care provider- in states, territories, and jurisdictions where it is illegal or where the legal status of EPT is unclear or ambiguous;
- Implementation of EPT where permitted by law and 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, unsuccessful, or unavailable;
- Development and dissemination of protocols, guidelines, and best practices for the implementation of EPT; and
- Additional research and evaluation to strengthen the evidence base for EPT and to determine the effectiveness of EPT among same-sex partners and for the treatment of trichomoniasis and syphilis.

Additionally, NACCHO encourages local health departments to work with health care providers in their community to promote the implementation of EPT by increasing awareness of the practice and providing information and resources regarding its implementation and legality.

Justification

Chlamydia and gonorrhea present significant public health challenges. In 2010, a total of 1,307,893 chlamydial infections and 309,341 cases of gonorrhea were reported in the United States, representing the first and second most commonly reported notifiable diseases in the country.¹ The highest rates for both chlamydia and gonorrhea were observed among women aged 15-19 years and 20-24 years. Under-reporting is substantial for both diseases because most people are not aware of their symptoms and do not seek testing, so it is estimated that incidence of these infections is even higher. The CDC estimates that 2.8 million chlamydial infections and 700,000 cases of gonorrhea occur annually- more than double what is reported.^{2,3}

Many sex partners of persons with chlamydial infection or gonorrhea are not treated, which leads to frequent reinfections and further transmission.⁴ Partner notification to assure treatment of infected persons' sex partners has been an essential component of prevention and control of



bacterial sexually transmitted infections (STIs) in the U.S. since the 1940s.⁵ The standard approaches to notifying and treating a partner of an STI-infected patient are patient referral and provider referral, however 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 medical providers have the resources to do so.⁷

EPT offers an additional strategy for partner notification and management, which is particularly valuable when other strategies are impractical or unsuccessful. Study results have shown that as compared to standard referral of partners, EPT for chlamydia and gonorrhea significantly reduced persistent or recurrent infections among patients.⁸ (Research to date does not support the use of EPT for persons diagnosed with other STIs, including HIV, and is insufficient to support the use of EPT with same-sex partners.⁹) Additionally, preliminary economic analyses suggest that EPT is a cost-saving and cost effective partner management strategy,¹⁰ which is particularly important for local health departments given the impact the economic recession has had on budgets, staff, and programs.¹¹

EPT for the treatment of gonorrhea and chlamydia in heterosexual partners is endorsed by the CDC through its *STD Treatment Guidelines*. The CDC also developed a legal/policy toolkit to assist in the adoption of laws supportive of EPT and/or facilitate the implementation of statutes or regulations that permit EPT in clinical practice.¹² EPT is also supported by professional organizations, including the American Medical Association, the American College of Obstetricians and Gynecologists, and the Society for Adolescent Health and Medicine, and in 2008, the American Bar Association House of Delegates passed a resolution urging the removal of legal barriers to implementing EPT nationally.¹³

Despite the effectiveness of EPT, legal, medical, practical, and administrative barriers can hinder routine use by healthcare providers. The primary barrier to implementing EPT is its illegal or uncertain legal status. As of June 2012, EPT was permissible in 31 states and Baltimore, Maryland; potentially allowable in 12 states, the District of Columbia, and Puerto Rico; and prohibited in 7 states.¹⁴ Where EPT is potentially allowable, additional actions or policies must be taken, such as specific interpretation of inconsistent or amorphous provisions, support for policies consistent with legal authorization, and incorporation by reference into treatment guidelines.¹⁵ Even in states where EPT is legal, challenges arise from providers' perception that the practice is illegal or that it presents a substantial legal liability risk for prescribing or dispensing antibiotics to their patient's sexual partners without a prior examination of those partners.¹⁶ 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 STI and HIV co-infections; and incomplete treatment/noncompliance. To address these challenges, providers and policy makers must collaborate to remove legal barriers and facilitate reimbursement, as well as collaborate with health departments for implementation assistance.¹⁷

Concerns regarding adverse drug effects and/or 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 in which adverse events have been monitored since 2001, no drug-related adverse effects or lawsuits arising from this type of care have been documented.¹⁸ Currently, there is no evidence that EPT leads to increasing antibiotic resistance at a population level.^{19,20} 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 health care provider.

As stated in EPT guidance documents in California and Illinois, “Doing nothing for the sex partners on individuals diagnosed with chlamydia or gonorrhea is more harmful than not offering EPT.”^{21,22} Additionally, the inadequacies of current approaches to partner notification and the persistence of unacceptably high levels of morbidity from STIs in the U.S. should motivate the legalization and implementation of EPT.²³ EPT is a particularly important tool for local health departments in jurisdictions with high rates of gonorrhea and chlamydia and/or those with limited resources for other partner notification methods.

Record of Action

Approved by NACCHO Board of Directors

March 11, 2009

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References

1. Centers for Disease Control and Prevention. (2010). *Sexually Transmitted Disease Surveillance 2010*. Atlanta, Georgia: U.S. Department of Health and Human Services. Retrieved December 27, 2011 from <http://www.cdc.gov/std/stats10/surv2010.pdf>.2.
2. Centers for Disease Control and Prevention. (2011). Chlamydia: Fact Sheet. Atlanta, Georgia: U.S. Department of Health and Human Services. Retrieved December 28, 2011 from <http://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm>
3. Centers for Disease Control and Prevention. (2011). Gonorrhea: Fact Sheet. Atlanta, Georgia: U.S. Department of Health and Human Services. Retrieved December 29, 2011 from <http://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea.htm>
4. Golden, M., Whittington, W., Handsfield, H., Hughes, J., and Stamm, W. et al. (2005). Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydia infection. *New England Journal of Medicine* 352(7): 676-685.
5. Centers for Disease Control and Prevention. (2006). *Expedited partner therapy in the management of sexually transmitted diseases*. Retrieved December 28, 2011 from <http://www.cdc.gov/std/treatment/EPTFinalReport2006.pdf>
6. Burstein, G., Eliscu, A., Ford, K., Hogben, M., Chaffe, T, et al.. (2009). Expedited Partner Therapy for adolescents diagnosed with chlamydia or gonorrhea: A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health* 45: 303-309.
7. *Ibid.*
8. Golden, M., Whittington, W., Handsfield, H., Hughes, J., and Stamm, W. et al. (2005). Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydia infection. *New England Journal of Medicine* 352(7): 676-685.
9. *Ibid.*
10. Centers for Disease Control and Prevention. (2006). *Expedited partner therapy in the management of sexually transmitted diseases*. Retrieved December 28, 2011 from <http://www.cdc.gov/std/treatment/EPTFinalReport2006.pdf>
11. National Association of County and City Health Officials. (2011). Local health department job losses and program cuts: Findings from July 2011 survey. Washington, DC.

12. Centers for Disease Control and Prevention. (2011). Expedited Partner Therapy Legal/Policy Toolkit. Atlanta, Georgia: U.S. Department of Health and Human Services. Retrieved December 29, 2011 from <http://www.cdc.gov/std/ept/legal/legaltoolkit.htm>.
13. American Bar Association. (2008). Report to the House of Delegates. Retrieved December 29, 2011 from http://www.americanbar.org/content/dam/aba/migrated/health/04_government_sub/media/116A_EPT_Final_authcheckdam.pdf.
14. Centers for Disease Control and Prevention. (2012). Legal status of Expedited Partner Therapy. Atlanta, Georgia: U.S. Department of Health and Human Services. Retrieved on June 12, 2012 from <http://www.cdc.gov/std/ept/legal/default.htm>
15. *Ibid.*
16. Burstein, G., Eliscu, A., Ford, K., Hogben, M., Chaffe, T, et al.. (2009). Expedited Partner Therapy for adolescents diagnosed with chlamydia or gonorrhea: A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health* 45: 303-309.
17. *Ibid.*
18. *Ibid.*
19. California Department of Public Health, STD Control Branch. (2007). Patient-delivered partner therapy for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*: Guidance for medical providers in California. Retrieved December 29, 2011 from <http://www.cdph.ca.gov/healthinfo/discond/Documents/Chlamydia-PDPT-Guidelines-Ptnr-Info.pdf>
20. Illinois Department of Public Health. (2010). Expedited Partner Therapy for *Chlamydia Trachomatis* and *Neisseria Gonorrhoeae*: Guidance for Health Care Professionals in Illinois. Retrieved December 29, 2011 from http://www.idph.state.il.us/health/std/Illinois_EPT_Guidelines172010.pdf.
21. California Department of Public Health, STD Control Branch. (2007). Patient-delivered partner therapy for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*: Guidance for medical providers in California. Retrieved December 29, 2011 from <http://www.cdph.ca.gov/healthinfo/discond/Documents/Chlamydia-PDPT-Guidelines-Ptnr-Info.pdf>
22. Illinois Department of Public Health. (2010). Expedited Partner Therapy for *Chlamydia Trachomatis* and *Neisseria Gonorrhoeae*: Guidance for Health Care Professionals in Illinois. Retrieved December 29, 2011 from http://www.idph.state.il.us/health/std/Illinois_EPT_Guidelines172010.pdf.
23. Golden, M., Whittington, W., Handsfield, H., Hughes, J., and Stamm, W. et al. (2005). Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydia infection. *New England Journal of Medicine* 352(7): 676-685.