Expedited Partner Therapy: Growing Policy and Practice

NCSD
National Coalition of STD Directors
Promoting Sexual Health Through STD Prevention

EPT has become a routine practice for STD treatment and prevention in the U.S.

Expedited partner therapy (EPT) is a strategy for ensuring that the exposed sex partner(s) of patients diagnosed with a sexually transmitted disease (STD) get the necessary antibiotic treatment to cure their infection. Treating a patient's sexual partner(s) is crucial to prevent the spread of the infection and stop the patient from becoming reinfected. Partners of infected patients should be strongly encouraged to seek STD testing and treatment from a health care provider, but due to social, financial, or logistical barriers, this does not always occur. When a patient is diagnosed and treated for chlamydia, or gonorrhea, and their partner(s) is unwilling or unable to seek treatment, EPT enables a health care professional to provide the patient with either antibiotics or a prescription for antibiotics for his/her sexual partner(s) without requiring the partner(s) to physically visit a health care professional.[1,2]

Patients diagnosed with gonorrhea or chlamydia that use EPT in consultation with a health care provider are more likely to report that their partner(s) received treatment and they are less likely to be diagnosed with another infection at a follow-up visit.[3] A large study of Washington state's EPT program suggests that the practice lowered STD infection rates by approximately ten percent for both chlamydia positivity and gonorrhea incidence.[4] However, due to operational and policy barriers, EPT is not an allowable practice in every state. The Centers for Disease Control and Prevention (CDC) encourage individuals, local and state health departments, and other organizations interested in STD prevention to address barriers to maximize the STD prevention impact of EPT.[5]

Need more information?
Contact NCSD's state policy team at 202-842-4660
or statepolicy@ncsddc.org.
Visit our website at www.ncsddc.org.

[1]National Coalition of STD Directors "Expedited Partner Therapy: Reducing Health Care Costs and Creating Health Communities." Washington, DC. Accessed March 4, 2015.via: http://www.ncsddc.org/sites/default/files/printable_ept_fact_sheet.pdf
[2]*A recent trend shows states expanding EPT policy to include trichomonisasis.*
[3]The Centers for Disease Control and Prevention "Expedited Partner Therapy." Atlanta, GA: US Department of Health and Human Services. Accessed March 4, 2015. via: http:// www.cdc.gov/std/ept/
[4]Golden, M, Kerani, R, Stenger, M, Hughes, JP, Aubin, M, Malinski, C, and Holmes, KK. "Uptake and Population-Level Impact of Expedited Partner Therapy (EPT) on *Chlamydia trachomatis and Neisseria honorrhoeae:* The Washington State Community-Level Randomized Trail of EPT" PLoS Med 12(1) (2015).
[5]The Centers for Disease Control and Prevention "Dear Colleague Letter from John M. Douglas, Jr., MD., Director, Division of STD Prevention on the legal status of EPT." December 19, 2006. Accessed on April 10, 2015 via: http://www.cdc.gov/std/ept/dearcolleagueeptlegal12-19-2006.pdf
[6]California Department of Public Health "Patient-Delivered Partner Therapy (PDPT) for Chlamydia, Gonorrhea, and Trichomoniasis: Guidance for Medical Providers in California." Accessed March 4, 2015.via: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/CA-STD-PDPT-Guidelines.pdf
[7]The Centers for Disease Control and Prevention. "Legal/Policy Toolkit for Adoption and Implementation of Expedited Partner Therapy." Accessed March 4, 2015. via: http://www.cdc.gov/std/ept/legal/ept-toolkit-complete.pdf
[8]The Centers for Disease Control and Prevention. "Legal Status of Expedited Partner Therapy (EPT)." Accessed June 16, 2015.via: http://www.cdc.gov/std/ept/legal/
[9]See note 7.
[10]Cramer, R, Leichliter, JS, Stenger, MR, Loosier, PS, and Slive, L. "The legal aspects of expedited partner therapy practice: do state laws and policies really matter?" Sexually Transmitted Disease 40(8) (Aug 2013): 657-62.
[11]Rubinstein, E. "Comparative safety of the different macrolides". International Journal of Antimicrobial Agents, (2001):18:S71-6.
[12]Washington HB 1538 and New York AB 1919
[13]See note 1.
[14]The Centers for Disease Control and Prevention. "2013 Sexually Transmitted Disease Surveillance Report."Atlanta, GA: US Department of Health and Human Services. Accessed March 5, 2015 via: http://www.cdc.gov/std/stats13/toc.htm
[15]The Centers for Disease Control and Prevention. "2010 Sexually Transmitted Diseases Surveillance." Atlanta, GA: US Department of Health and Human Services. Accessed March 5, 2015 via: http://www.cdc.gov/std/stats10/gonorrhea.htm
[16]The Centers for Disease Control and Prevention "Legal/Policy Toolkit for Adoption and Implementation of Expedited Partner Therapy." Accessed April 10, 2015 via: http://www.cdc.gov/std/ept/legal/ept-toolkit-complete.pdf
[17]See note 16.
[18]The Centers for Disease Control and Prevention. "2015 Sexually Transmitted Disease Guidelines." Atlanta GA: US Department of Health and Human Services. Accessed June 12, 2015 via: http://www.cdc.gov/std/tg2015/tg-2015-print.pdf

How has EPT progressed in the U.S.?

California was the first state to explicitly allow EPT in 2001 and since then, many states have followed suit.[6] An analysis of state EPT laws by CDC in 2006 concluded that only 10 states expressly permitted EPT, but by 2010, CDC reported that number had grown to 27 states.[7] As of June, 2015, EPT was allowable in 37 states.[8]

The maps to the right show the status of EPT in the United States in 2006 and 2015. EPT is legally permissible in any state shaded green; likely prohibited in red states; and potentially allowable in yellow states. EPT is legally permissible when laws, or governing authorities, expressly allow the practice or there are statutes that adopt CDC's STD treatment guidelines, which effectively endorse EPT as long as there is no contrary statutory provision.[9]

Do state laws and policies really matter?

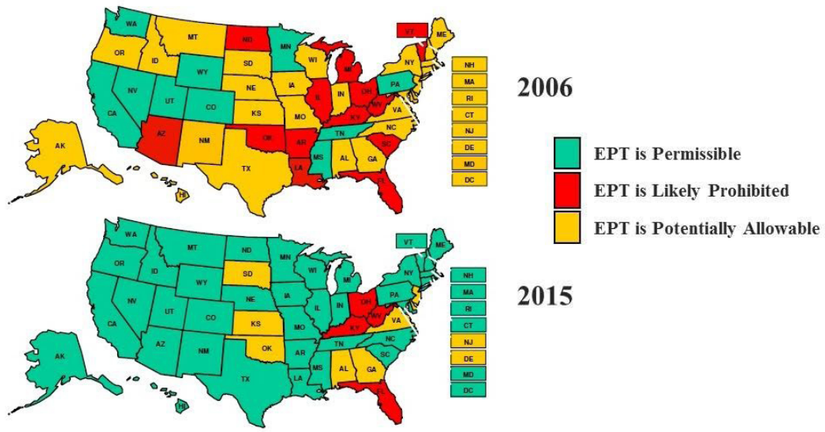
Given the success of EPT in reducing sexually transmitted disease reinfections and the low risk of adverse effects associated with its use, policy efforts have focused on facilitating its practice.

A 2013 report analyzing the legal aspects of EPT and the influence of state laws and policies on the use of EPT, found that explicit laws or regulations that permitted EPT were associated with higher reports of individuals receiving EPT among interviewed STD cases. The study suggested that laws that authorize EPT may diminish provider concern for legal liability, and that for jurisdictions wanting to use of EPT, the study suggests supportive law and policies may be an effective option for doing so.[10]

Those states that do not allow EPT (red states in the map above) often do not have an explicit statutory prohibition against the use of EPT but instead, have statutes that contain detailed stipulations about patient-provider relationships that in practice make the provision of EPT unlawful.

In those states where EPT is potentially allowable (yellow states in the above map), there are no statutes that would prohibit EPT such as a requirement that physicians have a preexisting relationship with the individual for whom he/she is writing a prescription or providing medication, but these states often have other provisions that make EPT difficult to administer.

Evolving Landscape of EPT: Legal Status Summary



Which states have taken action on EPT?

Over the past decade, many state legislatures have taken action to legalize EPT and/or make it allowable. NCSD has been a part of the policy process in many of these states by helping to facilitate coalitions, creating materials, and providing organizational support.

Most recently, several state legislatures and a city council took steps to legalize and/or make EPT feasible. Policymakers in Ohio, Maryland, Hawaii, Michigan, Kentucky, West Virginia, Nebraska, Vermont, and the District of Columbia have all taken steps in this direction. The EPT legislation in all of these states was similar in that each modified state code to allow a provider without a preexisting relationship, or examination, to prescribe or dispense antibiotics for STD treatment. In most cases, EPT legislation also adds language to state codes to protect health care providers from liability from any poor outcomes associated with EPT use. While poor outcomes are extremely rare[9] (there have been no reported adverse effects from the use of EPT), physician associations tend to be more comfortable with EPT legislation when it contains liability protection. The Hawaii, Nebraska, and Vermont legislatures successfully passed EPT bills in 2013, and Michigan and DC passed EPT bills in 2014.

In states such as New York and Washington, where EPT is available already, legislatures are working to either expand the group of providers that can provide EPT or the diseases that can be treated with EPT.[12]

Remaining states where EPT is not available, such as Ohio, continue to pursue changes to EPT policy as programs across the US show EPT to be an effective strategy for STD treatment and cost-saving preventative care.[13]

CDC's EPT endorsement

In 2006, CDC in its Sexually Transmitted Diseases Treatment Guidelines, recommended EPT as an evidenced-based option to manage chlamydia and gonorrhea by treating the initial patient and any sex partner(s) to prevent reinfection and curtail further transmission.[16] EPT is also recommended in the updated guidelines from 2010 and 2015. Since CDC's 2006 recommendation, other organizations have supported EPT, including the American Bar Association, American Medical Association, Society for Adolescent Health and Medicine, American Academy of Pediatrics, and American Congress of Obstetricians and Gynecologists.[17]

In addition to CDC's recommendation of EPT, the 2015 CDC STD Guidelines explicitly recommend the delivery of EPT by providing patients with appropriately packaged medication as the preferred approach to EPT, as compared to providing prescriptions. The data on the efficacy of EPT through providing prescriptions is very limited, and many persons do not fill prescriptions given to them by their partner.[18]

What can state policymakers do?

EPT can be a challenging topic since each state has different medical practice laws. In some states, regulations by medical boards prohibit doctors from using EPT. In other states, statutes may prevent the practice of EPT. CDC's EPT website (www.cdc.gov/std/ept/legal) can help legislators understand the legal landscape in their state.

In addition, state policymakers can:

- Learn More – Talk to your state's STD director to discuss if EPT can be implemented in your state and the potential public health impact.
- Educate Others – Talk to other policymakers about how many people are infected with chlamydia and gonorrhea and the consequences of persistent infections.
- Talk to Us – NCSD has assisted a number of states with EPT policy education and we are ready to provide officials with information about EPT and its potential impact on STDs.

Contact us at: StatePolicy@ncsddc.org,
202-842- 4660, or visit www.ncsddc.org.

What is the status of EPT in our state?

Is EPT allowable in our state?

No, EPT is not allowable in West Virginia.

Our state's regulation on a health care providers' ability to prescribe STD treatment to a patient's partner(s) without prior medical evaluation reads:

Statutory authority requires a physician patient relationship prior to prescribing medications. Pharmacists are also precluded from dispensing drugs where the intended recipient is not the patient identified on the prescription.

Almost 1.4 million cases of chlamydia and almost 333,000 cases of gonorrhea were reported in the U.S. in 2013.[14]

In our state, the most recent data shows that the number of chlamydia cases reported was:

In 2014, 4,719 cases of chlamydia were reported in West Virginia. A rate of 254.5 cases per 100,000 population.

In our state, the most recent data shows that the number of gonorrhea cases reported was:

In 2014, 841.0 cases of gonorrhea were reported in West Virginia. A rate of 45.4 cases per 100,000 population.

In addition to the public health benefits, EPT could save the state money. An estimated $850 million is spent annually treating chlamydia and gonorrhea in the U.S.15 EPT can decrease health care costs by reducing the spread of infections and reinfections, and the reliance on public services to treat STDs. Please refer to your state department of public health for more state specific information.