

Expedited Partner Therapy: Innovative Health Policy Reduces Sexually Transmitted Infections and Prevents Infertility

By Ann V. Kelly

Expedited partner therapy allows clinicians to treat the sex partners of patients diagnosed with chlamydia or gonorrhea prior to evaluating the partners, under certain conditions. Innovative and cost-effective, expedited partner therapy is legal in 22 states and is an increasingly important state prevention policy to reduce infections and their consequences, including infertility.

In August 2009 Illinois joined 21 other states that endorse an innovative approach to control sexually transmitted infections known as expedited partner therapy, when Gov. Pat Quinn signed Senate Bill 212. The bill was strongly supported by a coalition of health care organizations and passed with minimal opposition in the legislature.¹

By approving expedited partner therapy, states allow partners of patients diagnosed with chlamydia or gonorrhea to receive antibiotics without being seen by a medical provider. Expedited partner therapy helps patients diagnosed with sexually transmitted diseases avoid reinfection by getting treatment for their sexual partners who are either unable or unwilling to see a medical professional. Expedited partner therapy can be accomplished a few different ways. When patients are diagnosed, medical providers can give them antibiotics they can take to their sexual partners. In other situations patients are given prescriptions for their partners, or patients tell partners where to obtain antibiotics from a pharmacy or public health program. The treatment used for partners is generally a one-time dose of antibiotic with low potential for allergic and other adverse reactions. In all cases, patients should also receive written instructions for their partners on how to take the medication, and health information including how long to abstain from sex after treatment and encouragement to seek evaluation by a health care provider.

Expedited partner therapy provides clinicians with an additional tool in treating sexual partners in complicated situations. Patients can be unwilling to give the names of their partners to health officials. Since the diseases frequently occur without symptoms, partners may refuse to see a doctor because they think they are not infected. Partners

also may lack health coverage or access to a trusted health provider, or they may have concerns about confidentiality or cost of such a health care visit.

Expedited partner therapy was first endorsed by public health officials to supplement traditional approaches of contacting and treating sexual partners.² It has become a more important tool because of the large number of people infected with these curable infections, the reluctance of patients and medical providers to make referrals to health officials, and the financial constraints limiting health departments' ability to contact the sexual partners of those with chlamydia and gonorrhea. When used appropriately, expedited partner therapy typically has higher success in getting sexual partners treated compared to other patient referral approaches. California health officials recently compared expedited partner therapy success to other approaches used in family planning centers. They found that although a majority of patients used traditional partner referral with only a 40 percent success rate, patient-delivered partner therapy (California's version of expedited partner therapy) was used for one in five patients and achieved a 77 percent success rate.³

Disparities and Preventing Infertility and Other Consequences

Chlamydia is the most common reported sexually transmitted infection in the U.S., and the Centers for Disease Control and Prevention estimates that nearly 3 million people are newly infected each year. New gonorrhea infections are less common, occurring in about 700,000 Americans annually, and like chlamydia, it is curable and preventable. Since both of these sexually transmitted infections often occur without symptoms, about half of those

who are newly infected each year are undiagnosed and untreated, and can suffer the consequences of the diseases, including infertility.^{4,5} (For specific state information, see state profiles at <http://www.healthystates.csg.org>.)

Teenage girls have the highest number of reported infections, accounting for about 25 percent of the five most common sexually transmitted infections.^{6,7} Reported rates of chlamydia among African-American women are eight times higher than among white women, and three times higher than among Hispanic women. Although gonorrhea infections occur less often, rates for this infection are 16 times greater among African-American women than their white counterparts. For both infections, the highest rates in women occur in African-American females ages 15 to 19, followed by African-American women ages 20 to 24; similar racial disparities exist among young males. Among American Indian and Hispanic populations, teen girls and young women have chlamydia and gonorrhea infection rates that are two to three times higher than white women.^{8,9}

About 15 percent of women with untreated chlamydia and gonorrhea can develop pelvic inflammatory disease, which can lead to infertility and recurring chronic pain, and tubal pregnancy, a condition that can be life-threatening to the mother. In addition, chlamydia infection increases a woman's risk of contracting HIV from a sexual partner. For pregnant women, chlamydia may lead to premature delivery and can cause infection in their babies.^{8,10,11} The Centers for Disease Control and Prevention estimates that undiagnosed and untreated sexually transmitted infections cause infertility in at least 24,000 American women each year. The costs of treating these preventable conditions are significant for both public and private health insurers, particularly in states requiring health coverage for infertility. Fifteen states mandate some coverage for infertility treatment: Arkansas, California, Connecticut, Georgia, Hawaii, Illinois, Maryland, Massachusetts, Montana, New Mexico, New York, Ohio, Rhode Island, Texas and West Virginia.^{8,12,13}

To prevent these sexually transmitted infections and their complications, the CDC recommends annual chlamydia testing and treatment for all sexually active females under age 26, as well as older women with risk factors such as a new sex partner or multiple partners. Annual chlamydia testing of sexually active young women has been recommended by the U.S. Preventive Services Task Force

since 1996. In addition, since 2000 the Healthcare Effectiveness Data and Information Set quality measures have included chlamydia testing statistics, both for commercial health insurance plans and Medicaid managed care plans. In spite of these recommendations, only about 40 percent of sexually active females enrolled in health plans were tested in 2007. The regional testing rates were highest in the Northeast (46 percent) and lowest in the South (37 percent), indicating that additional testing by U.S. health care providers is needed to reduce the preventable consequences of chlamydia infection among young women.¹⁴ Annual testing for gonorrhea in high-risk sexually active women also is recommended by the U.S. Preventive Services Task Force. Patients diagnosed with either infection are counseled to take antibiotics, and to encourage their sexual partners to be treated. Expedited partner therapy allows patients to actively participate in getting their partners treated and thus avoid becoming reinfected, and avoid resulting harmful effects such as infertility.^{11,12}

Legal Status of Expedited Partner Therapy

Expedited partner therapy is expressly permitted in 22 states and Baltimore, Md., according to the CDC. Although legally prohibited in eight states, expedited partner therapy is potentially allowable from a legal standpoint in the 20 remaining states, Washington, D.C., and Puerto Rico.^{14,15} The legal basis for expedited partner therapy varies from state to state, but is established through legislation, regulation and modification of state medical, nursing and pharmacy practice laws.¹¹ In addition, state public health departments issue appropriate care guidelines for clinicians that specify the types of patients and antibiotics best suited for expedited partner therapy as an option for partner therapy.^{16,17,18,19,20,21}

Since expedited partner therapy allows clinicians to provide prescription medications to people they have not examined, medical providers and pharmacists may believe the practice to be unethical, fear sanctions by state licensing boards or have concerns about malpractice liability. Without specific legislation that endorses expedited partner therapy, providers may be concerned about the legality of the practice.²²

That said, states have taken different approaches to addressing professional liability related to use of expedited partner therapy. Utah House Bill 17 and Illinois Senate Bill 212, both adopted in 2009, specifically state that medical practitioners who use

expedited partner therapy according to the guidelines are not liable for medical malpractice, unless their actions constitute willful or wanton misconduct. In other cases, liability issues are addressed in state guidelines used to educate providers considering use of expedited partner therapy. For example, the California guidelines for medical practitioners state:

“This liability is no different from the liability of any other action taken by a health care provider, including prescribing or dispensing medicine for any medical condition, in which the provider remains liable. However, guidelines establish a standard of care, and standard of care is the primary medicolegal standard for appropriate practice.”²⁰

State actions supporting expedited partner therapy are based on recommendations from the CDC. In 2006 the CDC indicated that expedited partner therapy should be available to providers as an option for treating the partners of individuals with chlamydia and gonorrhea infections. Based on expert evaluation of clinical trial results, expedited partner therapy was an effective and potentially cost-saving approach to treating sexual partners and reducing reinfection in diagnosed patients. The CDC’s guidelines for treating sexually transmitted diseases also describe when clinicians should consider using expedited partner therapy in partner treatments.^{23,24,25} Using expedited partner therapy under prescribed conditions also has been supported by the American Medical Association,²⁶ the American Bar Association,²⁷ the Society for Adolescent Medicine, the American Academy of Pediatrics,²⁸ and the National Association of County and City Health Officials.²⁹

State Policies to Prevent Sexually Transmitted Infections

Removing legal barriers to expedited partner therapy is one component of a comprehensive state approach to prevent sexually transmitted infections. In a recent survey, the American Social Health Association defined 11 components of state sexually transmitted infections prevention policies, including:

- *Clinical care policies:* Prenatal screening for sexually transmitted infections, expedited partner therapy, opt-out written consent for HIV testing in sexually transmitted infection clinics and mandated sexually transmitted infection-related vaccines;

- *Insurance coverage policy:* Mandated HIV and sexually transmitted infections testing;
- *Reporting policies:* Electronic laboratory reporting for sexually transmitted infections and related conditions, mandated vaccine data storage in immunization registry; and
- *Education policies:* Age appropriate and comprehensive sex education, comprehensive sexually transmitted infection and/or HIV prevention education, certification or training for sexuality and health education instructors, and use of a standardized state-approved curriculum.

The American Social Health Association found many of these approaches, like expedited partner therapy, are not widely adopted and in 15 states, none of the policies were in place. Seven “leader” states—Alabama, California, Hawaii, Illinois, Louisiana, Minnesota and Missouri—adopted at least five of the 11 approaches listed above. The survey also identified removing barriers to expedited partner therapy as one of the top four priorities for policy change in the states.

The ASHA survey also examined state prevention funding for the 2007 fiscal year and compared it to the cost of treatment for sexually transmitted infections. State sexually transmitted infection prevention program spending averaged 23 cents per capita from state sources and 60 cents per capita from federal funds. This prevention total of 83 cents per capita represented less than 2 percent of the \$49 per capita spent annually in the U.S. on sexually transmitted infection treatment. Profiles of the American Social Health Association survey results for each state are available at http://www.ashastd.org/stdpreventionfunding/rpt_funding.cfm.^{30,31,32}

The National Chlamydia Coalition is another national effort whose work supports state sexually transmitted infection prevention efforts. The coalition was initiated in 2008 to encourage wider testing for chlamydia and to reduce preventable infertility and other harmful effects of chlamydia among sexually active adolescents and young adults. Comprised of national nonprofit organizations, health care professional associations, advocacy groups, health insurers, and local, state and federal government representatives, the coalition provides resources for clinicians and public information tools to encourage wider interest and support for chlamydia testing and treatment, and more awareness of how to combat this often silent infection and its severe consequences. For more information, see <http://www.prevent.org/ncc>.³³

Implications for Future State Health Policy

As federal and state lawmakers consider expanded health insurance coverage, which will lead to greater use of prevention services, new opportunities exist for reducing the impact of sexually transmitted infections, including infertility.

As expanded health coverage increases access to prevention services among previously uninsured populations, other supportive efforts will be needed to increase use of these services. Allowing for full insurance coverage of sexually transmitted disease testing services without copayments and deductibles can eliminate payment barriers for patients. Health department communications can increase public and provider awareness and use of recommended sexually transmitted infection prevention services. Educating medical providers to perform recommended sexually transmitted infection prevention services for their patients will be more important if publicly-supported services are curtailed. For example Massachusetts, a leader in health access reform, has closed publicly funded sexually transmitted infection clinics in six locations outside Boston since 2008, presuming that those sexually transmitted disease services can be provided by general medical practitioners.³⁴

Health coverage reform should greatly reduce the role that lack of health insurance plays as a cause of health disparities, but other initiatives are needed to connect the previously uninsured with trusted sources of medical care and information about how to manage their sexually transmitted infections. Additional evidence is needed about the success of education, testing and prevention programs on reducing the burden of sexually transmitted infections and their consequences, particularly among African-American adolescents and young adults.³⁴ For more information, see The Council of State Governments' Overcoming Women's Disparities in Women's Sexual Health policy brief at <http://www.csg.org/pdfs/WomensHealth.pdf>.

Finally, given broader access to preventive health services under health reform and well-accepted evidence that chlamydia testing is a cost-effective practice, more testing and treatment of patients with chlamydia is anticipated. Since many chlamydia infections are undetected, wider testing will lead to a greater need for sexual partner treatment services, and greater demands on available health department resources. State health department funding continues to be reduced—more than three-fourths of state public health agency budgets were cut in the 2009 fiscal year and nearly 40 per-

cent expected further cuts in the 2010 fiscal year.³⁵ Sexually transmitted infection prevention program funding has also been reduced,³⁶ so health department programs that provide direct services (partner examination and treatment) will not have sufficient resources to respond to the increased demand. Expedited partner therapy could help address much of this anticipated increase in demand for partner treatment. Establishing a supportive legal environment for expedited partner therapy will enable states to implement this cost-effective public health practice, reduce infections and their serious consequences, including infertility.

This publication was supported by Cooperative Agreement 1H25PS00138-02 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

Notes

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Table A:
Prevention of Sexually Transmitted Infections
Expedited partner therapy legal status, STI prevention funding, and rates of chlamydia and gonorrhea infections by race/ethnicity

State or other jurisdiction	Expedited partner therapy legal status (a)	2007 per capita sexually transmitted infection prevention funding (b)				2008 reported chlamydia infections in women (per 100,000 population) (c)					2008 reported gonorrhea infections in women (per 100,000 population) (c)					
		State funds	Federal funds	Total	White	African-American	Hispanic	African-American		Asian	White	African-American	Hispanic	African-American		Asian
								Indian	Asian					Indian	Asian	
Alabama.....	Potentially Allowable	\$0.57	\$0.49	\$1.06	175	2,002	553	157	247	43	692	37	39	52		
Alaska.....	Potentially Allowable	0.09	0.76	0.85	501	2,123	766	4,456	1,251	32	260	96	507	109		
Arizona.....	Permissible	0.04	0.31	0.35	231	1,510	899	1,959	205	23	343	65	141	10		
Arkansas.....	Prohibited	0.52	0.45	0.97	380	3,215	873	353	716	54	967	92	80	102		
California.....	Permissible	0.15	0.37	0.53	187	1,580	761	368	204	21	390	48	49	14		
Colorado.....	Permissible	0.05	0.39	0.44	123	1,472	600	455	148	26	630	120	108	31		
Connecticut.....	Potentially Allowable	0.47	0.37	0.84	120	2,043	1,090	296	147	16	630	149	54	8		
Delaware.....	Potentially Allowable	0.14	0.53	0.67	299	2,103	1,707	...	97	52	581	134	...	19		
Florida.....	Prohibited	0.33	0.33	0.66	250	2,110	373	264	190	50	668	43	55	28		
Georgia.....	Potentially Allowable	0.00	0.47	0.47	98	1,035	270	443	84	20	367	33	108	28		
Hawaii.....	Potentially Allowable	0.63	0.38	1.01	232	748	449	329	395	15	97	44	...	41		
Idaho.....	Potentially Allowable	0.14	0.30	0.44	305	867	891	1,075	227	10	...	18	27	...		
Illinois.....	Permissible	0.06	0.52	0.58	236	2,850	981	110	122	41	1,004	128	46	11		
Indiana.....	Potentially Allowable	0.02	0.32	0.34	287	2,608	937	175	135	64	1,189	127	117	62		
Iowa.....	Permissible	0.05	0.30	0.34	387	4,096	1,112	1,422	387	47	1,286	89	181	47		
Kansas.....	Potentially Allowable	0.21	0.34	0.54	273	2,374	984	984	154	48	930	125	142	23		
Kentucky.....	Prohibited	0.25	0.27	0.52	191	1,570	565	202	88	46	728	64	...	44		
Louisiana.....	Permissible	1.55	0.66	2.20	220	2,003	...	48	...	56	666	...	19	...		
Maine.....	Potentially Allowable	0.01	0.30	0.31	270	1,428	109	240	268	6	165	19		
Maryland.....	Potentially Allowable	0.11	1.16	1.27	204	1,167	586	139	90	25	286	44	42	5		
Massachusetts.....	Potentially Allowable	0.19	0.24	0.43	111	1,431	1,172	702	262	8	248	89	94	11		
Michigan.....	Prohibited	0.30	0.30	0.59	194	1,826	494	310	145	35	708	95	45	18		
Minnesota.....	Permissible	0.06	0.24	0.31	224	3,191	1,247	1,580	652	29	856	80	195	38		
Mississippi.....	Permissible	0.26	0.51	0.77	239	2,189	177	1,955	360	51	664	40	498	39		
Missouri.....	Potentially Allowable	0.01	0.41	0.42	270	2,553	806	193	320	51	923	96	40	26		
Montana.....	Potentially Allowable	0.00	0.36	0.36	294	1,385	338	2,414	447	13	...	11	66	32		
Nebraska.....	Potentially Allowable	0.20	0.26	0.46	204	3,093	738	1,791	208	38	1,342	16	256	16		
Nevada.....	Permissible	0.00	0.22	0.23	243	1,530	595	487	293	36	405	53	67	36		
New Hampshire.....	Permissible	0.28	0.27	0.55	236	679	580	69	199	8	45	27	...	10		
New Jersey.....	Potentially Allowable	0.09	0.42	0.51	62	1,092	507	315	43	7	295	40	29	4		
New Mexico.....	Permissible	0.70	0.81	1.51	332	972	977	1,591	99	36	307	122	66	8		
New York.....	Permissible	0.09	0.59	0.68	133	1,298	546	385	103	16	276	50	69	7		
North Carolina.....	Permissible	0.14	0.61	0.75	289	2,094	1,145	937	345	63	733	124	412	49		
North Dakota.....	Permissible	0.05	0.51	0.56	255	2,089	521	2,069	196	16	330	52	159	98		
Ohio.....	Prohibited	0.08	0.32	0.40	213	2,158	651	246	156	46	850	107	90	48		

See footnotes at end of table.

Prevention of Sexually Transmitted Infections — continued

State or other jurisdiction	Expedited partner therapy legal status (a)	2007 per capita sexually transmitted infection prevention funding (b)			2008 reported chlamydia infections in women (per 100,000 population) (c)					2008 reported gonorrhea infections in women (per 100,000 population) (c)				
		State funds	Federal funds	Total	White	African-American	Hispanic	American Indian	Asian	White	African-American	Hispanic	American Indian	Asian
Oklahoma.....	Prohibited	0.02	0.39	0.41	401	2,842	910	1,058	369	83	1,284	133	186	29
Oregon.....	Permissible	0.14	0.39	0.53	322	1,735	986	719	242	27	313	51	29	12
Pennsylvania.....	Permissible	0.08	0.48	0.56	137	2,027	851	189	141	22	551	125	24	19
Rhode Island.....	Potentially Allowable	0.72	0.47	1.18	216	1,640	1,411	1,109	488	10	228	66	...	8
South Carolina.....	Prohibited	0.00	0.55	0.55	251	1,897	659	185	158	59	653	53	15	17
South Dakota.....	Potentially Allowable	0.15	0.38	0.53	368	1,443	736	4,171	310	29	316	...	634	39
Tennessee.....	Permissible	0.34	0.55	0.88	291	2,609	1,325	251	174	49	767	134	70	23
Texas.....	Permissible	0.20	0.34	0.54	343	2,042	1,109	173	199	66	750	143	45	29
Utah.....	Permissible	0.07	0.21	0.28	312	1,262	1,080	702	552	10	171	32	9	20
Vermont.....	Permissible	0.03	0.39	0.42	338	710	195	85	195	7	59
Virginia.....	Potentially Allowable	0.31	0.58	0.88	210	1,767	596	123	137	38	624	60	10	19
Washington.....	Permissible	0.10	0.49	0.59	306	1,638	1,189	982	353	27	329	58	94	24
West Virginia.....	Prohibited	0.00	0.46	0.46	234	1,229	435	59	240	38	397	73	...	55
Wisconsin.....	Potentially Allowable	0.01	0.30	0.31	239	3,398	836	1,116	429	33	1,400	122	240	35
Wyoming.....	Permissible	0.30	0.67	0.97	272	1,070	771	771	215	19	178	86	23	...
Dist. of Columbia ...	Potentially Allowable	1.35	4.36	5.71	46	1,549	712	2,130	159	8	556	107	355	50

Key: (a) Centers for Disease Control and Prevention, Legal Status of Expedited Partner Therapy (EPT), <http://www.cdc.gov/std/legal/default.htm> (accessed February 3, 2010).
 (b) American Social Health Association, State Investment in STD Prevention, Comparison Data, http://www.ashtd.org/stdprevention/funding/rpt_comp.cfm?_fvari=1 (accessed February 3, 2010).
 (c) CDC, National Center for HIV, STD and TB Prevention (NCHSTP), Division of STD/HIV Prevention, Sexually Transmitted Disease Morbidity for selected STDs by age, race/ethnicity and gender, 1996–2008, CDC WONDER On-line Database, November 2009, http://wonder.cdc.gov/std_v2008-race-age (accessed February 3, 2010).

More than 1 million sexually transmitted infections (STIs) are acquired every day worldwide (1, 2). Each year, there are an estimated 376 million new infections with 1 of 4 STIs: chlamydia, gonorrhoea, syphilis and trichomoniasis (1, 2).¹ In some cases, STIs can have serious reproductive health consequences beyond the immediate impact of the infection itself (e.g., infertility or mother-to-child transmission). The Gonococcal Antimicrobial Resistance Surveillance Programme has shown high rates of quinolone resistance, increasing azithromycin resistance and emerging resistance to extended-spectrum cephalosporins.² Symptoms or disease due to the incurable viral infections can be reduced or modified through treatment. Newsletter of the International Union against Sexually Transmitted Infections.³ The course is particularly aimed at young clinicians and Health Care Providers (HCPs) developing an interest in sexually transmitted infections, but all STI-interested colleagues from all IUSTI regions are invited. The programme of the course has by now been completed and is available on the Congress website (www.iusti2019.eu Programme: STI Course).⁴ STI Global Update is published by the International Union against Sexually Transmitted Infections. Its aims are to provide an international perspective on the management and control of sexually acquired infections. Prof. Jonathan Ross, Editor jonathan.ross@uhb.nhs.uk. The prevention and care of sexually transmitted disease is an intervention which improves the health status of the population and prevents HIV transmission. Consequently UNAIDS and WHO recommend that high priority be given to the development of programmes directed at this goal. The objective of this document is to outline the policies and principles for the prevention and care of sexually transmitted disease (STD) to assist Ministry of Health officials who have the responsibility of developing and implementing STD programmes.⁵ In primary prevention the aim is to prevent the acquisition of infection and disease. This can be done by promoting: ⁶ safer sexual behaviour Sexually transmitted infections (STIs) are a major public health concern in the United States. STIs are frequently asymptomatic and can lead to significant morbidity if left untreated. In recent years, the prevalence of STIs has risen significantly.¹ The Centers for Disease Control and Prevention (CDC) reports that in 2017 there were nearly 2.3 million cases of chlamydia, gonorrhoea, and syphilis, which represents a sustained increase over the past four years.⁷ Screening guidelines, recommendations, and programs have been developed with the goal of identifying and treating individuals with STIs in order to limit transmission, reinfections, and complications.¹ Though the prevalence of STIs is increasing, screening rates Sexually transmitted infections (STI) are a major global cause of acute illness, infertility and death. Every year there are an estimated 499 million new cases of the most common curable STIs (trichomoniasis, chlamydia, syphilis and gonorrhoea), and between two and three million new cases of HIV.⁸ PN for curable STI may prevent re-infection of the patient and reduce the risk of complications and further spread.⁹ Expedited partner therapy was more successful than simple patient referral in reducing repeat infection in patients with gonorrhoea, chlamydia or non-gonococcal urethritis (six trials). Expedited partner therapy and enhanced patient referral resulted in similar levels of repeat infection (three trials).