EXPEDITED PARTNER THERAPY IN KENTUCKY

A Call to Update Health Policy

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Contents

Executive Summary 3

Background 4

Solution 7

Call to Action 7

References 9

U.S. incidence rates for STIs are on an alarming rise

Providers utilizing Expedited Partner Therapy can increase treatment and decrease reinfection rates for their populations

Kentucky is one of two remaining states which has not legalized EPT for use in clinical practice, putting patients at risk

Executive Summary

Increasing incidence rates for sexually transmitted infections (STIs) are a major public health concern in the U.S. Innovative strategies have become necessary in the treatment of patients diagnosed with STIs and their partners due to continually rising rates of infection, transmission, and reinfection.

Expedited Partner Therapy (EPT) is an evidence-based approach for providers to increase partner treatment and decrease reinfection rates in patients with certain STIs. This clinical practice involves the treatment of exposed sex partners without examination by a healthcare provider. This is most commonly accomplished by patient-delivered partner therapy (PDPT), where diagnosed patients deliver medications or prescriptions to their sexual partner(s). EPT was endorsed by the Centers for Disease Control and Prevention (CDC) starting in 2006 as an effective treatment option for reducing chlamydia and gonorrhea transmission and reinfection rates in high-risk populations. However, state-based legislation governs practice implementation and *Kentucky (KY) remains one of two states which has not yet legalized the practice.* This delay in policy change poses a state health concern for continued spread of infection in at-risk populations as partners of patients diagnosed with STIs remain untreated.

This white paper informs readers of EPT and its indications, as well as the need for revision to KY state regulations to include this practice as legal and viable for healthcare provider use.

Expedited Partner Therapy in Kentucky: A Call to Update Health Policy

With a role as primary care providers in Kentucky (KY), Advanced Practice Registered Nurses (APRNs) have a duty to advocate on behalf of their patients for better health outcomes. While KY has made recent strides to match its neighboring states for many health promotion indicators, certain disease prevention initiatives in sexual health lag behind. The current KY Department of Public Health (DPH) sexually transmitted disease regulation has not been updated in over a decade.[1] Failure to modernize public health regulations in accordance with evidence-based practice leaves Kentuckians at risk for adverse outcomes and epidemiological crisis. APRNs who are fluent in both their state-based practice authority and current public health concerns have an increased opportunity for future success when lobbying for health regulation amendment. This white paper aims to inform KY APRNs about current sexually transmitted infection (STI) trends, the practice of Expedited Partner Therapy, and the impetus for revised sexual health regulations in KY.

Background

The dramatic increase in the incidence of many sexually transmitted infections (STIs) in the past decade demands attention from healthcare practice and policy. According to the Centers for Disease Control and Prevention (CDC), *Chlamydia trachomatis* infection continues to be the most common notifiable condition in the U.S. National surveillance data reflects over 1.7 million reported cases of chlamydia in 2017, accounting for a 6.9% increase over the previous year.[2] This rising trend is alarmingly consistent for many STIs, including those caused by *Neisseria gonorrhoeae* and *Trichomonas vaginalis*. The state of KY is not exempt from high STI transmission rates, with a reported 18,286 cases of chlamydia and 5,812 cases of gonorrhea in 2016.[3] These infections affect all genders, races, and socioeconomic groups in the state.

[1] Kentucky Legislative Research Committee, 2007
[2] Centers for Disease Control and Prevention (CDC), 2018
[3] CDC, 2017a

The related risks for long-term health complications are widely established; including the link to pelvic inflammatory disease (PID), chronic abdominal pain, human immunodeficiency virus (HIV), reproductive system cancers, epididymitis, and infertility. Because it is suspected that many cases go undiagnosed and unreported, current medical practice recommends antibiotic therapy for all partners exposed to the infected index case, regardless of the diagnostic testing result, in an effort to prevent both morbidity in the partner(s) and further transmission.[4]

Expedited Partner Therapy (EPT) emerged in 2006 as a CDC-endorsed, evidence-based practice to increase treatment for chlamydial and gonorrheal infections in an effort to reduce transmission and reinfection rates.[5] Whereas standard practice has relied on index patient referral for partner notification, EPT allows clinicians to provide STI-diagnosed patients with medication or a prescription to deliver to their partner(s) as treatment for exposure. This eliminates the requirement for in-person medical evaluation of the partner and expedites the treatment process. The most common way this therapy is accomplished is through patient-delivered partner therapy (PDPT), where a diagnosed patient in a clinic setting is provided medications or prescriptions to deliver to their exposed partners for treatment. A meta-analysis of randomized-controlled trials (RCTs) found that use of EPT reduced reinfection by 20-29% for certain STIs and resulted in increased partner treatment as compared to standard partner referral.[6] Evidence from multiple RCTs has shown that EPT is an effective and beneficial strategy for patients with certain STIs who are at risk for loss to follow up.[5]

Due to the unconventional practice of treating individuals without a physical examination, utilization of EPT is governed by individual, state-based regulations. Those states with large, urban populations became the first to adopt the practice in order to maximize treatment for exposed partners with limited access to healthcare. Since CDC-endorsement in 2006, nearly all states have updated their regulations to authorize provider use of EPT in the clinical setting. While it is currently legal and utilized in 48 states, EPT remains prohibited in KY (illustrated in

[4] Hopson & Opiola McCauley, 2017
[5] CDC, 2006
[6] Ferreira, Young, Mathews, Zunza, & Low, 2013

Figure 1).[7] KY DPH regulation "902 KAR 2:080. Sexually transmitted diseases", which standardizes how clinicians screen for, treat, and report STIs remains untouched since 2007. Two separate amendment attempts were proposed to include EPT in 2014 and 2015. These bills did not gain traction in the KY House of Representatives and died in committee before moving to a floor vote. It has been speculated that lack of knowledge and visible sponsorship at legislative and stakeholder levels contributed towards bill failure.[8]

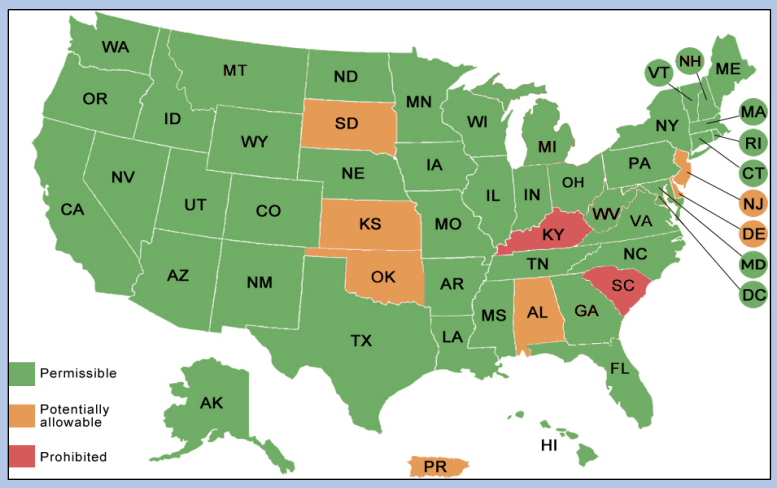

Figure 1. State-based legal status of Expedited Partner Therapy.

Delay in policy change poses a concern for continued spread of infection in at-risk KY populations as partners of patients with diagnosed STIs remain untreated. Those with low socioeconomic status, low health literacy, and decreased access to healthcare are disproportionately at risk for complications related to STIs, making this a clear issue of health equity.[9] When evaluating strategies for decreasing transmission, EPT addresses these factors by increasing treatment availability, decreasing cost to both the state healthcare system and the patient, and addressing personal behavior by mitigating risk for reinfection. Consequently, the practice aligns with the current DPH Kentucky State Health Improvement Plan for improving integration to healthcare access.[10]

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[7] CDC, 2018b
[8] M. Marzian, personal communication, February 5, 2019
[9] CDC, 2015
[10] Kentucky Department of Public Health (KY DPH), 2017

Solution

While EPT cannot eradicate bacterial transmission, it is a partial and viable solution to combat the continually-increasing STI incidence rates. The lack of DPH regulation amendment supporting EPT in KY limits provider options in caring for patients diagnosed with certain STIs. This practice would be a benefit to many patients in the commonwealth; especially for those patients who are high-risk and partners who may not have access to health care or choose not to pursue physical examination. Therefore, legislation in KY should be updated to include explicit health policy allowing EPT use according to CDC recommendations and provider discretion as they collaborate with their patients to formulate safe, efficacious treatment plans.

Both the healthcare and legislative arenas are complex organizations which require adaptability to ever-changing environments. Integrating an evidence-based practice into state policy requires evaluating many interdependent factors contributing to legislative success and failure. The opening of a policy window of opportunity is not always easy to predict, and timing, value acceptability, and advocacy become major influences in determining the outcome of a regulation amendment. Stakeholder support of a proposed agenda is key to its success.[11]

Call to Action

APRNs are in an advantageous position to address health disparities due to their increasing presence as primary care providers and stakeholders in KY healthcare. Many avenues can lead to practice changes that impact patients, health promotion, and disease prevention. By directly influencing policy, legislation and regulation amendments are prominent means for change.[12] With a basis in nursing, APRNs are trained to address patients and medicine holistically, giving them the opportunity to be transformational leaders in their communities and influential advocates for policy change in the political arena. Nurse practitioners must raise the alert at the legislative level for practice change needs that otherwise may be overlooked by policymakers who are unversed in current epidemiological and health crises.

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[11] Kingdon, 2003

[12] Mason, Gardner, Outlaw, & Grady, 2016

State representatives and senators are most directly responsible for presenting new health policy to the respective House and Senate for approval. A sponsor is needed for committee formulation and bill proposal. While the next legislative session will not begin until January 2020, advocates for EPT are needed to raise awareness of STI transmission and therapeutic, evidence-based practice alternatives to standard practice inadeqacies. APRNs are encouraged to reach out to their coalition leaders and legislators to stimulate conversation on EPT and the related need for practice change as policy advocates work towards the opening of a window of opportunity for STI regulation amendment in KY. For further information regarding current recommendations for EPT use, providers are encouraged to visit the CDC website and review the 2015 Sexually Transmitted Diseases Treatment Guidelines.[13]

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[13] CDC, 2018c; CDC, 2015

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