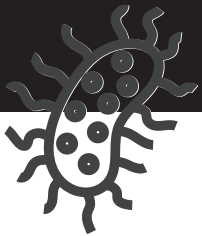


Expedited Partner Therapy (EPT): Considerations for Policymakers

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Background on Sexually Transmitted Infections (STIs)



Sexually transmitted infections (STIs) are more **common** than many people think.

Estimates suggest that about **20 percent** of the U.S. population have an STI at any given time.

Two common bacterial STIs are chlamydia and gonorrhea. In 2022, about 1.65 million Americans were diagnosed with chlamydia and 648,056 were diagnosed with gonorrhea. In many cases, these infections do not have easily identified symptoms, so unless people are routinely tested they **might not know** they have an STI. This is a challenge for prevention because chlamydia and gonorrhea can **spread** regardless of the presence of symptoms.

Left untreated, **chlamydia** and **gonorrhea** can have severe health consequences. For women, both infections can cause pelvic inflammatory disease, which can have negative effects on fertility. Untreated chlamydia and gonorrhea can also cause infertility in men, although that outcome is rare. In addition to causing individual suffering, medical costs associated with STIs are significant. In 2018, lifetime medical treatment for new STIs cost an estimated **\$6 billion**.

One challenge for **STI prevention** is that the risk of **reinfection** is high if a person's partner(s) do not receive necessary treatment. This failure to treat partners contributes to **persistently high STI rates**. When a person is diagnosed with an STI, the diagnosing health care provider should advise the patient to **notify their partner(s)** of a potential exposure and suggest that the partner(s) seek testing at a health care facility. This process is called **standard partner referral** or unassisted partner referral, and it does not necessarily ensure that partners will seek testing and treatment. When partners do seek treatment, many **do not do so immediately**, leaving a period where they could infect their partner again or pass the infection to others. Methods that increase the number of partners who seek treatment and decrease the gap between notification and receiving treatment are important to interrupt the chain of STI transmission. Expedited partner therapy (EPT) is one such method.

What is EPT?

EPT is a method of delivering timely treatment to the partner(s) of a person diagnosed with chlamydia and/or gonorrhea.



The **premise** is that the original patient's health care provider furnishes them with the medication needed to treat themselves and any partners they identify. This eliminates the need for the person's partner(s) to visit a health care facility. Health care providers can do this in one of **two ways**: providing the necessary medication(s) directly to the patient or providing prescriptions for the original patient's partner(s). Although EPT is not appropriate for all situations, it is a useful tool for health care providers to have at their disposal.



What Questions Remain About EPT?



One question relates to the **effectiveness** of EPT delivered by prescription compared to EPT delivered as medication. Most of the studies that underpin the Centers for Disease Control and Prevention's (CDC) EPT **recommendations** gave medication directly to patients, but prescription-EPT is **more common** in practice.

Evaluating the effectiveness of prescription-EPT could help establish best practices for this method of treatment. Additionally, the CDC's EPT-specific **guidelines** from 2006 recommend consideration of EPT for partners of heterosexual men and women "when other management strategies are impractical or unsuccessful." These guidelines also allow for selective EPT use among men who have sex with men (MSM), but note that effectiveness data are lacking for this population. The CDC reiterated the need for research evaluating EPT use among MSM in its 2021 **Sexually Transmitted Infections Treatment Guidelines**. Establishing the effectiveness of EPT among MSM is another area for additional research.

EPT and Antimicrobial Resistance

Improper use of antibiotics contributes to antimicrobial resistance, the process by which bacteria gain full or partial immunity to a medication. Overuse of antibiotics at the population level and individual behaviors, such as not finishing the full course of prescribed antibiotics, are examples of **improper use**. Antimicrobial resistance is of particular concern for gonorrhea, as it has developed resistance **to all but one** class of antibiotic used to treat it.

Although the CDC still **recommends** oral EPT for gonorrhea if there is reason to believe that a person's partner(s) will not or cannot seek prompt treatment, the preference is that partner(s) are evaluated and treated by a health care provider, because the recommended antibiotic for treating gonorrhea is given by injection.



Why Should Public Policy Support Implementation of EPT?

EPT can benefit individuals diagnosed with STIs, partners of individuals diagnosed with STIs, and society. Helping a person ensure that their partner receives treatment prevents them from potentially becoming reinfected. For the partner, receiving medications or a prescription without having to seek treatment themselves makes obtaining treatment easier. Together, these benefit society because fewer people have STIs that they can potentially spread. Additionally, EPT is a **cost-effective** intervention and treats more partners than standard referral. Finally, providers often include information about preventing STIs when they dispense EPT, which may help people make behavioral changes that can further decrease their risk of reinfection. For policymakers concerned about the health of their constituents or health care expenditures, it is worth recognizing the benefits of EPT.

Policy Considerations to Support EPT Implementation

EPT is legally permissible in **46 states** and potentially allowable in the remaining four but remains **underutilized**. As with most policies, ensuring that real-world practice changes after a policy passes requires more than simply advancing legislation. It is no different for legislation that legalizes EPT. Addressing some **associated policies** can make it more feasible for health care providers to implement EPT when the circumstances call for its use.



Prescription-related Rules

- Some states require a patient’s **identifying information** (e.g. name, birth date) be included on every prescription. For EPT, this can be a barrier to implementation because there are situations where a person may not know this information or may not want to share this information about their partner(s). Instead, allowing health care providers to issue **nameless** EPT prescriptions allows for broader use.
- Ensuring that the law allows providers to issue and pharmacists to fill **non-electronically transmitted prescriptions** for EPT is important. This can be key because not all **electronic health record systems** can initiate EPT prescriptions and it may be easier for a patient to provide EPT to their partner(s) with a paper prescription.
- Some states have **other rules** that can make EPT less likely to be implemented effectively. For example, requiring that a patient pick up their own medication from a pharmacy, prohibiting pharmacists from filling prescriptions for people who have not been physically examined by a health care provider, or requiring that a provider-patient relationship be established are rules that can make EPT legalization ineffective.



Provider Liability

Several **studies** have found that health care providers may not be comfortable prescribing EPT because they are **concerned** about the potential **liability** ramifications if a patient they have not physically examined has an adverse reaction to the medications. Passing legislation that protects health care providers from liability or malpractice litigation if they prescribe EPT can help minimize these concerns. The idea is similar to “**Good Samaritan**” laws that protect individuals who intervene in an emergency if they were acting in good faith.



Financial Considerations

From a patient perspective, **filling** an EPT prescription for a partner will require the patient to either pay cash for the prescription or obtain insurance information for their partner—both of which may be hindrances to the goal of providing treatment for partners. Some states allow EPT prescriptions coverage under the initial patient’s **insurance**, potentially decreasing the financial burden of filling the prescription.

Additionally, there is reason to believe that it is more **effective** to provide the **medication** for EPT rather than a prescription. In some particularly vulnerable communities with **high STI transmission**, it may make sense to explore the **costs and benefits** of a health agency buying **medication in bulk** to distribute to providers.

Conclusion

EPT is not a silver bullet to stop the spread of STIs; however, it is worth clearing policy obstacles that discourage its use. Enabling health care providers to use EPT when it is appropriate for their patients empowers both parties to choose the partner treatment method that is most likely to work in their unique situation. Despite concerns about antimicrobial resistance and a need for more research, policies should not inadvertently limit the use of EPT.

