

Evaluation of Expedited Partner Therapy (EPT) Uptake and Effectiveness for Chlamydia/Gonorrhea

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Background

- Expedited Partner Therapy (EPT) is the practice of treating sex partners of persons with STDs without an intervening clinical exam of that partner.
- In May of 2008 through an amendment to the state pharmacy statute in Minnesota, the legal barriers to EPT implementation were removed.
- The CDC guidelines for EPT were adopted by the Minnesota Department of Health (Figure 1).

Objectives

- To conduct an EPT pilot project in one or more clinical settings to evaluate the uptake and effectiveness of EPT for patients diagnosed with chlamydia and gonorrhea.
- To evaluate the incorporation of EPT into standard medical care for persons diagnosed with chlamydia and gonorrhea.

Project Description

In the spring of 2010, the Minnesota Department of Health implemented a pilot project in twelve clinics that ended in December 2011. The EPT pilot clinics that would have the most impact on the morbidity on patient populations in Minnesota were selected to participate.

EPT pilot clinics received ongoing technical assistance, partner packs for each index patient and up to three partners, as well as quarterly reports summarizing clinic-specific and overall project data. The partner packs (Figure 2) consisted of medication for chlamydia, gonorrhea, or both, and contained materials of instructions introducing the treatment, potential side effects, contact information, and material about the infection. Information in the packs was provided in both English and Spanish. The EPT pilot clinics in return sent the Minnesota Department of Health minimal contact information for the index case and data about the utilization of partner packets on a weekly basis.

The Minnesota Department of Health conducted confidential telephone interviews with the index patient two weeks after accepting or rejecting EPT. Interviews were conducted in both English and Spanish. EPT pilot clinics were sent a follow-up survey upon completion of the pilot project to provide feedback on their utilization of EPT and future plans to continue use of EPT in their clinic settings.

Figure 1. EPT Materials Created by the Minnesota Department of Health

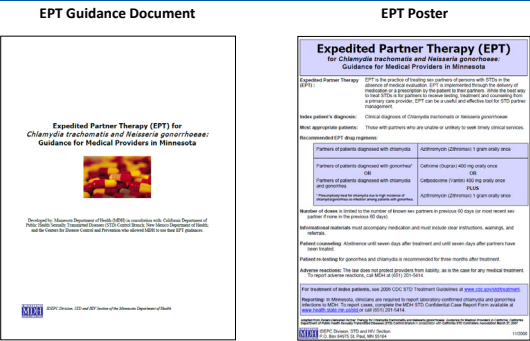


Figure 2. Chlamydia and Gonorrhea Partner Packs

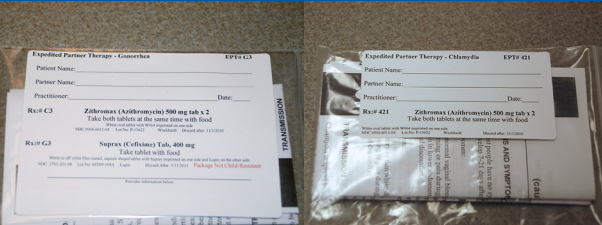


Figure 2. Who did you offer EPT to?

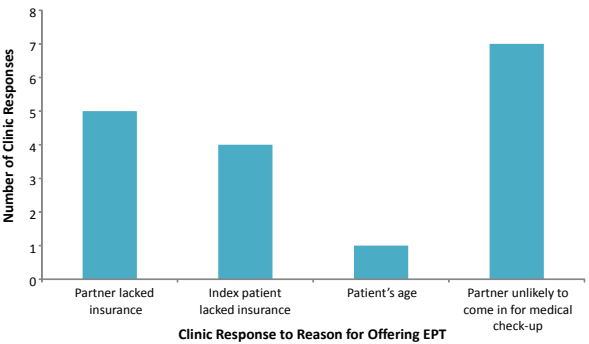


Figure 3. How will EPT be provided going forward?

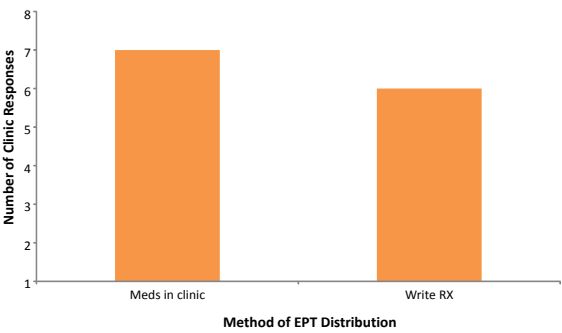


Figure 4. Final Interview Outcome

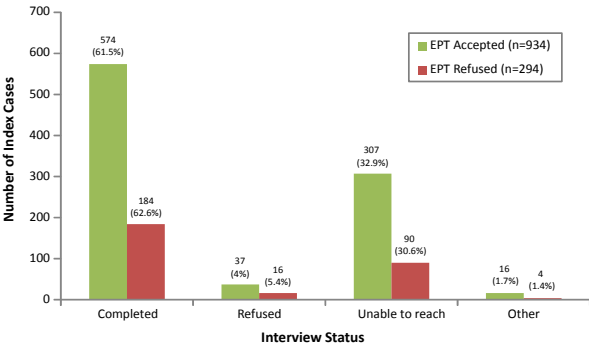


Figure 5. Speak to partners about STI exposure?

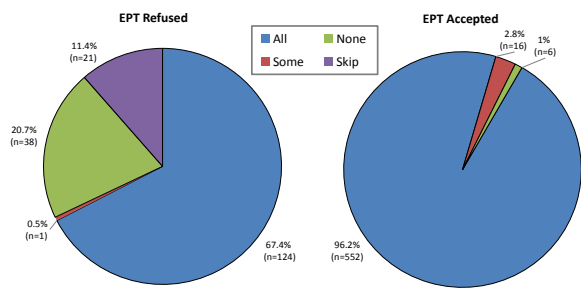


Figure 6. Why refuse EPT?

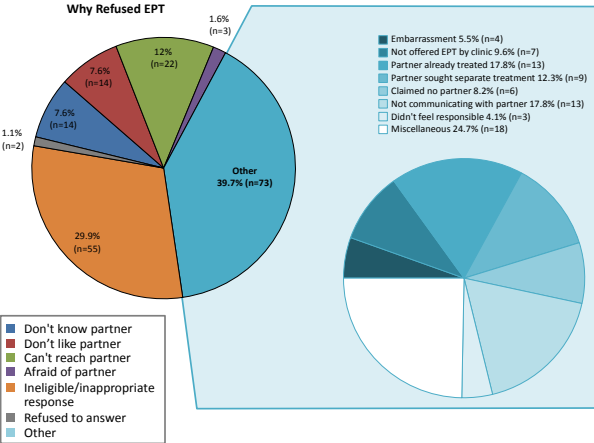
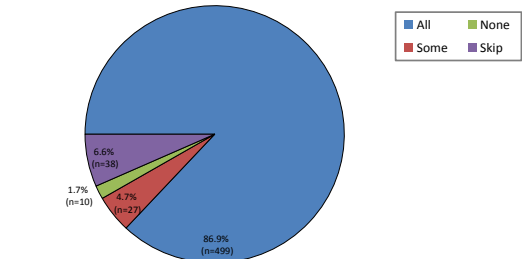


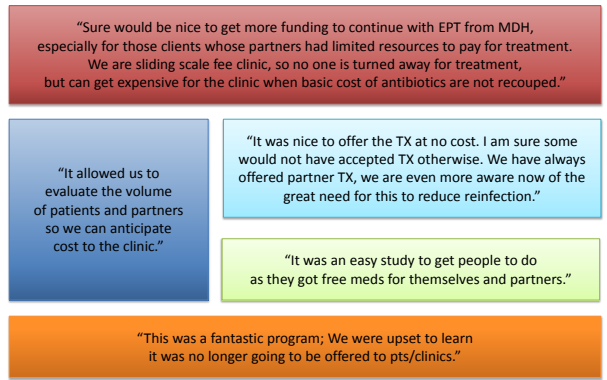
Figure 7. How sure partner completed EPT treatment?



Findings

- Implementing the EPT pilot was found to be very resource intensive. A considerable amount of staff time was spent on assembling, delivering, and tracking packets for the clinics as well as providing ongoing technical assistance, identification and preparation of surveillance case report forms to acquire contact information, and conducting index case follow-up phone calls.
- The total cost of medications and EPT pack supplies was approximately \$30,000, in addition to staff time.
- Estimating the amount of medication needed was difficult.
- Expiration dates of medications received were determined by our vendor and sometimes medications expired before they were used and therefore needed to be destroyed.
 - This resulted in higher expenses due to repurchasing of medications.
- At clinic request we allowed the provision of EPT for MSM patients and found acceptance rate to be slightly higher.
- The percentage of patients offered EPT has varied by clinic from 3%-67%.
- Of the 1228 patients offered EPT to-date, 76% (934) accepted and 24% (294) refused.
- Interviews were conducted on 758 (62%) patients offered EPT.
 - Of those interviewed 92% (526) were certain that all or some of their partner(s) had completed the EPT treatment.

Figure 8. Clinic Survey Comments



Conclusions

- Most patients that were offered EPT, accepted EPT, and their partner(s) utilized the delivered medication.
 - Clinics that participated in the pilot found that there is a need for EPT medication in the clinic, but the expense can be a barrier to clinics.
 - Clinics should assess their patient population when planning for EPT implementation, as this will determine who is offered EPT and therefore impact both the success and the costs associated with using EPT.
- Compliance with the recommendation to abstain from sexual activity for seven days after treatment could reduce reinfection (data not shown).

Implications for Programs, Policy, and Research

- To establish EPT as a permanent intervention, clinics must consider funding, available staff resources, and potential barriers such as insurance reimbursement.
- It's important to ensure compliance with pharmacy law for package and medication labeling when providing packets from the clinic.
- The clinics are ultimately responsible for the diagnosis of cases and treatment of cases and their partners.
- The successful implementation of EPT could adversely affect the incidence of cases in a jurisdiction due to the lack of diagnosis and subsequent report of sexual partners.

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