



RESOLUTION: 50(20)

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SUBJECT: Support for Expedited Partner Therapy

PURPOSE: 1) Develop a clinical policy supporting the use of expedited partner therapy. 2) Develop model legislation that removes legal obstacles to expedited partner therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care professionals that choose to prescribe expedited partner therapy. 3) Work with state and local health departments and key stakeholders to develop expedited partner therapy protocols.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, Sexually transmitted infections (STIs) in America are at all-time highs and increasing; and

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3 WHEREAS, From 2014 to 2018, gonorrhea cases increased by 63% to over 583,000 cases and chlamydia
4 increased by 19% to 1.8 million cases – the most ever reported to the Centers for Disease Control (CDC)¹; and

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6 WHEREAS, The rate of ED patients with STIs has risen more quickly than the general increase of ED
7 patients and from 2009-2013 there was a 39% increase in ED visits that included an STI diagnosis²; and

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9 WHEREAS, Patients at highest risk for STIs are more likely to have poor access to healthcare and thus rely
10 on the ED for their care³⁻⁵; and

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12 WHEREAS, STIs are a matter of health disparities and ED patients treated for STI are more likely to be non-
13 white, younger, and lower-income^{2,6}; and

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15 WHEREAS, Untreated STIs can increase susceptibility to HIV and has especially harmful effects for women
16 by causing pelvic inflammatory disease, which the CDC estimates causes infertility in 24,000 women in the U.S. each
17 year⁷; and

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19 WHEREAS, STIs are a preventable drain on the healthcare system economy carrying an estimated lifetime
20 cost of \$678 million attributed to gonorrhea and chlamydia⁸; and

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22 WHEREAS, Traditional methods of partner notification (informing partners of patients with STIs of their
23 exposure) have yielded poor results and in areas of highest infection rates partner notification rates were as low as
24 12% and 17% for chlamydia and gonorrhea, respectively⁹; and

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26 WHEREAS, Expedited partner therapy (EPT) is the practice of treating sex partners of persons with a
27 laboratory-confirmed STI without medical evaluation of the partners to treat and prevent ongoing transmission of
28 STIs; and

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30 WHEREAS, EPT is recommended for heterosexual partners who are unlikely to access timely evaluation and
31 treatment and EPT provides source patient counseling, written instructions for the partner on treatment and
32 prevention, and uses drugs with a low risk of anaphylaxis and medications are dispensed with instructions about
33 adverse effects; and

34 WHEREAS, Partners receiving EPT are encouraged to seek additional medical evaluation as soon as possible
35 to discuss screening for other STIs, including HIV infection; and

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37 WHEREAS, In randomized controlled trials, EPT has shown to be more effective compared to unassisted
38 referrals at decreasing rates of source patient reinfection or persistent infection compared to standard partner referral
39 and in a systematic review of trials of over 12,000 patients there were no drug-related adverse effects or allergic
40 reactions reported¹⁰⁻¹²; and

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42 WHEREAS, California established a hotline to record any adverse events from EPT prescriptions and
43 received no calls for the full 10 years it was running and similarly, according to the Centers for Disease Control and
44 Prevention (CDC), there have been no cases of malpractice associated with the practice of EPT¹³; and

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46 WHEREAS, EPT is recommended by the CDC, American College of Obstetrics and Gynecology, American
47 Academy of Family Physicians, American Osteopathic Association, Society of Adolescent Medicine, American
48 Academy of Pediatrics, and the American Bar Association; and

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50 WHEREAS, EPT has gained legal acceptance in many states over the past decade because of state-specific
51 pharmacy or medical board decisions and the passage of state laws or regulations allowing the practice; and

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53 WHEREAS, EPT is currently permissible in 44 states, potentially allowable in 5 states (Alabama, Kansas,
54 New Jersey, Oklahoma, South Dakota, Puerto Rico), and only prohibited in South Carolina; therefore be it

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56 RESOLVED, That ACEP develop a clinical policy supporting the use of expedited partner therapy; and be it
57 further

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59 RESOLVED, That ACEP develop model legislation that removes legal obstacles to expedited partner
60 therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care
61 professionals that choose to prescribe expedited partner therapy; and be it further

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63 RESOLVED, That ACEP work with state and local health departments and key stakeholders to develop
64 expedited partner therapy protocols.

References

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Background

This resolution calls for ACEP to: 1) develop a clinical policy supporting the use of expedited partner therapy; 2) develop model legislation that removes legal obstacles to expedited partner therapy, promotes legal clarity where the laws are ambiguous, and provides legal protection for health care professionals that choose to prescribe expedited partner therapy; and 3) work with state and local health departments and key stakeholders to develop expedited partner therapy protocols.

Expedited partner therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. The [CDC](#) reports that cases of STIs have steadily increased since 2014. Limited resources mean that many partners are unable to receive standard treatment. The [CDC](#) has also concluded that, although ongoing evaluation is necessary, EPT is a useful option to facilitate partner management.

Currently, 45 states allow EPT (instead of 44 as reflected in the Whereas statement). It is potentially allowed in four states (instead of five as reflected in the Whereas statement), and prohibited in South Carolina. Some states have created programs specifically geared towards EPT. In 2014, the [Illinois Department of Public Health](#) used EPT along with other education to improve treatment outcomes in gonorrhea and chlamydia. The Minnesota Department of Health has created online guidance for using [EPT for Chlamydia trachomatis and Neisseria gonorrhoeae](#). Both states found that more education on EPT was needed both for the public and practitioners.

While ACEP has a clinical policy on [Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy \(2016\)](#), there is not a clinical policy specifically on EPT or STI transmission. The [American Osteopathic Association \(AOA\)](#) has a statement advocating for the use of EPT. [The American Academy of Family Physicians \(AAFP\)](#) also has a statement in support of EPT.

There is research that supports EPT as an effective option to facilitate partner management. A [clinical trial](#) published in 2010 found that EPT was superior to standard partner referral across a wide spectrum of sociodemographic and behaviorally defined subgroups. A [randomized controlled trial](#) from 2011 found that EPT was less costly and it treated more partners than standard partner referral. A [Cochrane Systematic Review](#) published in 2013 concluded that more research was needed on EPT. A [randomized controlled trial](#) published in 2015 concluded that more education is needed in order to make EPT effective.

An ACEP clinical policy supporting expedited partner therapy could provide guidance and education to members on the use of EPT. Model legislation could provide further guidance, specifically in states where EPT is potentially allowable or prohibited. Partnering with state and local health departments could provide education to the public, while providing protocols for practitioners.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Goal 2 – Enhance Membership Value and Member Engagement

Objective C – Provide robust communications and educational offerings via the website and novel delivery methods.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

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