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Expedited Partner Therapy: A Review for the Pediatric Nurse Practitioner

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ABSTRACT

The rate of sexually transmitted infections in the United States increased in 2015 for the second year in a row. Adolescents bear an undue portion of this burden because of increased physiologic susceptibility, higher rates of reinfection, and developmental age. Despite expedited partner therapy (EPT) being legalized in 39 states, health care providers still report infrequently providing EPT to their adolescent patients. Patients who benefit most from EPT include those with high-risk sexual behavior, a steady relationship status, higher education level, or an established relationship with the provider. This article will review the barriers to providing EPT and factors associated with patient acceptance or refusal, highlight current legal issues, and discuss the role of the pediatric nurse practitioner addressing specific strategies for implementation in practice. EPT is a valuable tool for the pediatric nurse practitioner to promote treatment and prevent reinfection with sexually transmitted infections. J Pediatr Health Care. (2017) ■, ■-■.

KEY WORDS

Expedited partner therapy, patient-delivered partner therapy

There were 1,526,658 cases of chlamydia and 395,216 cases of gonorrhea reported in the United States in 2015, and most of those cases were in adolescent or young adult women (Centers for Disease Control and Prevention [CDC], 2016b). Women with untreated or recurrent chlamydia are at increased risk for developing pelvic inflammatory disease, sterility, and ectopic pregnancy (CDC, 2016a). Traditional sex partner notification involves treating the index patient; subsequently, the patient notifies his/her partner(s), or the health care provider must elicit contact information for the index patient's sex partner(s) from the past 60 days (Burstein et al., 2009). See Table 1 for a comprehensive list of relevant terminology. In 2006, the CDC created the first guidelines for providing expedited partner therapy (EPT) to heterosexual patients for the treatment of chlamydia and gonorrhea (Hodge, Pulver, Hogben, Bhattacharya, & Brown, 2008).

EPT is the practice of prescribing antibiotics for a patient to give to his/her partner(s) without an evaluation of the partner by a clinician. EPT is an alternative method of providing partner services when a patient's partner would otherwise not likely receive any services. Patients who receive EPT are less likely to be reinfected, and more of their partners are likely to be treated (Ferreira, Young, Mathews, Zunza, & Low, 2013; Golden et al., 2005; Kissinger et al., 2005; Schillinger et al., 2003; Shiely et al., 2010). Adolescents are a patient population who could greatly benefit from EPT because they are disproportionately affected by sexually transmitted infections (STIs).

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Although adolescents make up only a quarter of the sexually active population, 15- to 19 year-olds account for 50% of all newly acquired STIs (Tulloch & Kaufman, 2013). Chlamydia and gonorrhea reinfection are more common in adolescent females, typically because of higher physiologic susceptibility to chlamydia and gonorrhea infection and continued sexual contact with untreated partners (Ricks et al., 2015; Tulloch & Kaufman, 2013). Health care providers report infrequently offering EPT to their adolescent patients because of perceived barriers (Lee, Dowshen, Matone, & Molen, 2015). There is a gap in the existing literature on the prevalence and efficacy of EPT in adolescents as compared with adults. This article will review the current practice of providing EPT to adolescents in the United States, specifically the barriers to and acceptance of EPT and the legal and policy implications.

BARRIERS TO PROVIDING EPT

Surveys within the last 10 years of physicians and nurse practitioners who commonly treat STIs show that most providers use EPT but do so inconsistently (Hogben, McCree, & Golden, 2005; Jotblad et al., 2012; Lee et al., 2015; Rosenfeld et al., 2015). Perceived barriers contribute to the inconsistency in providing EPT. In studies of health care provider perspectives on providing EPT, the most commonly cited barriers included legal status of EPT, missing an opportunity to counsel the partner, difficulty ensuring delivery of the medication, and concern for adverse drug effects (Burstein et al., 2009; Jotblad et al., 2012; Lee et al., 2015; Rosenfeld et al., 2015). Additionally, some providers cited cost of medication and administrative challenges as barriers to providing EPT. Barriers that were cited specifically regarding adolescents included parental consent, right to confidentiality, and partner age when mandatory reporting of statutory rape is required (Burstein et al., 2009; Lee et al., 2015).

TABLE 1. Definition of terms

Term	Definition
Expedited partner therapy	Prescribing antibiotics for a patient's sex partner without prior examination of the sex partner by a health care provider (Burstein et al., 2009; Golden et al., 2005; Shiely et al., 2010)
Patient-delivered partner therapy	An alternative term for expedited partner therapy (Jotblad et al., 2012; Kissinger et al., 2005; Schillinger et al., 2003)
Index patient	The patient who initially tests positive for an STI (Golden et al., 2005)
Patient referral	The index patient notifies his/her partner(s) to seek STI testing (Burstein et al., 2009)
Provider referral	The health care provider notifies the index patient's partner(s) to seek STI testing (Burstein et al., 2009)

Note. *STI, sexually transmitted infection.*

Legal Status

The legal status of EPT is the most commonly cited barrier to providing EPT. Despite increasingly more states passing laws to legalize EPT, a surprisingly large number of providers are unaware of the legal status in the state in which they practice. A survey of physicians across nine states with a variety of state policies on the legal status of EPT found that 50% of providers in states where EPT is legal were unaware of the legal status. In states where the legal status of EPT is less clear, an even greater percentage of providers did not know the legal status of EPT (Lee et al., 2015). Studies have concluded that because health care providers are unaware of the legality of EPT in their state of practice, they are less likely to provide EPT to patients because of fear of litigation or censure by medical boards (Lee et al., 2015; Rosenfeld et al., 2015). The Figure provides a map of where EPT is legal in the United States to date.

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Partner Counseling

Because EPT is delivered by the index patient, health care providers are often reluctant to pass up the opportunity to provide counseling that would have occurred during an encounter with the partner (Burstein et al., 2009; Jotblad et al., 2012; Lee et al., 2015; Rosenfeld et al., 2015). EPT does not provide an opportunity to collect the partner's history, screen for high-risk behavior, test for STIs, or discuss possible signs and symptoms of infection. This can become problematic if the index patient fails to explain to his/her partner that it is necessary for the partner to take the medication even if he/she is asymptomatic (Temkin, Klassen, Mmari, & Gillespie, 2011). Even though the goal of EPT is to provide services to partners who might not otherwise receive them, the lack of counseling by a health care provider may result in inaccurate information being provided by the index patient or a lack of comprehension by the partner. Adolescents are at a higher risk for not accepting EPT from their sex partner because they are less likely to consider the