Expedited Partner Therapy: A Harm Reduction Tool for Local Health Departments

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Abstract

Background: Expedited Partner Therapy (EPT) is essential for combating sexually transmitted infections (STIs), yet its adoption is limited in local health departments (LHDs).

Purpose: This quality improvement project aimed to assess and emphasize the necessity of enhancing EPT utilization in LHDs and to bolster STI prevention.

Methods: Examined existing EPT usage and identified implementation obstacles. Proposed strategic measures for wider adoption involving a review of a southern state's STI data, STI clinic protocols, and insights from the STI Access and Availability Survey. Conducted onsite training sessions for LHD STI personnel. After these sessions, participants utilized an evaluation tool to gauge their agency's ability to incorporate EPT, their comfort in prescribing EPT, and identified barriers to EPT integration within their LHDs

Results: Out of the three LHDs that participated in this project, only one intended to implement or expand EPT. Additionally, 83% of participants with prescriptive authority felt comfortable or extremely comfortable prescribing EPT.

Conclusions: The hurdles pinpointed in the uptake of EPT by clinicians in LHDs include concerns related to clinic staffing and EPT not within the scope of the enhanced role registered nurse (ERRN).

Implications for Nursing: Enhancing EPT uptake necessitates addressing systemic barriers and promoting provider readiness in LHDs and buy-in to expand the enhanced role registered nurse (ERRN) scope to include EPT.

Keywords: expedited partner therapy, sexually transmitted infections, local health departments, implementation barriers

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Background

In a southeastern state, eighty-six local health departments (LHDs) deliver state-mandated services, such as managing communicable diseases and controlling sexually transmitted infections. Kovar et al. (2019) report that all health departments in the state are legislatively mandated to provide sexually transmitted infections (STIs) screening, diagnosis, and treatment to anyone seeking such care in their facilities.

Among these agencies, twenty-five provide Expedited Partner Therapy (EPT) services, covering either Gonorrhea, Chlamydia, or Trichomoniasis, though not all three. Additionally, seven offer EPT for all three infections. This is a health equity concern for the residents of this state who need treatment for STIs.

Current Knowledge

EPT represents a clinical strategy endorsed by the Centers for Disease Control and Prevention (CDC) for addressing the sexual partners of individuals diagnosed with chlamydia, gonorrhea, and trichomoniasis (CDC, 2021). This method involves prescribing partners prescription medication without requiring a medical examination or testing. EPT's effectiveness hinges on the diagnosed individual providing medication or a prescription to their partners. The transmission of undiagnosed STIs may result in persistent or recurrent infections and can cause serious health complications (Jamison et al., 2018). Recognizing EPT as a best practice for reducing reinfections of STIs, the CDC reports that as of 2021, 46 states, including this one, have endorsed EPT, albeit with varying levels of implementation and guidance (CDC, 2021).

The state operates within a decentralized public health framework characterized by a distributed governance and service delivery approach across its counties and regions. Under this

model, LHDs enjoy significant autonomy, enabling them to tailor public health strategies to their communities' unique needs and priorities. Operating independently under the oversight of local boards of health, each LHD can develop responsive initiatives that reflect the diversity of the state's population and geography. While this decentralized structure fosters local innovation and adaptability, it also presents challenges in achieving statewide uniformity and coordination. Nonetheless, this state's decentralized approach underscores a commitment to community engagement and collaborative decision-making in public health endeavors, promoting inclusivity and equity in health outcomes.

The Communicable Disease Branch (CDB) provides practice guidance, epidemiological surveillance, and outbreak mitigation strategies to LHDs for STIs and communicable diseases. Notably, there exists a terminological distinction between the CDC and CDB regarding sexually transmitted infections; while the CDC uses "sexually transmitted infections" (STIs), the CDB employs "sexually transmitted disease" (STD). This discrepancy persists when referencing this state's LHD clinics and CDB reports. Despite the endorsement of EPT by the state's CDB, the regulation of its implementation in state-mandated STI clinics remains within the purview of individual agencies.

Purpose Statement

This project aimed to increase EPT uptake in LHDs by educating key stakeholders and local public health leaders that EPT is an evidence-based harm reduction tool. This evidence-based practice can reduce STI prevalence rates in counties throughout the state.

Methodology

The methodology encompassed a thorough review of state level infection (STI) data, including examining current standing orders, policies, and agreement addenda specific to STI

clinics. Additionally, insights were gleaned from the annual STI Access and Availability survey analysis. This annual survey is administered by the medical consultation unit of the CDB. It aims to capture a snapshot of services provided in individual LHDs and share best practices across jurisdictional boundaries. For instance, there is one respondent per LHD who answers questions related to STI clinic staffing, types of services offered and partnerships with community stakeholders to reduce STI infection rates and promote safe sexual practices.

Interventions

To raise awareness and comprehension of EPT, clinic leaders and clinicians from three LHD STI Departments received one-hour onsite education sessions. The initial session was conducted with LHD leadership to discuss EPT and how it could benefit the patients their LHD serves. Clinic leaders were mainly concerned with the financial implications of adding or expanding the services offered in their clinics.

The second sessions were conducted during the lunch hour with clinical staff. These sessions covered crucial topics such as the significance of EPT uptake within their agencies, insights into 340B funding, the legal status of EPT in the state, and successful EPT implementation models observed in other states. In total, there were sixteen participants in the onsite sessions.

Data collection for this study was conducted through questionnaires, primarily focusing on qualitative data obtained from surveys completed by LHD staff following the hour-long education session. The University and Medical Center IRB prescreened the project and did not require an IRB review.

The evaluation tool included questions aimed at understanding participants' roles and experience levels within their LHD. It further assessed the impact of the presentation on their

knowledge of EPT and their belief about their agency's capacity to incorporate EPT into clinical practice. For the participants with prescriptive authority, it examined their comfort level with prescribing EPT. Overall, the survey questioned the perceptions of the usefulness of the EPT template in policy development and perceived barriers to EPT uptake within their STI clinic.

Results

Sixteen staff members engaged in the onsite education training and completed the evaluation tool. Among these participants, twelve were clinicians, defined as providing direct patient care, with six possessing prescriptive authority. Additionally, three participants were clinical leaders, while one had a dual role as medical director and patient care provider. Regarding public health experience, four participants reported 0-5 years, two reported 6-10 years, four reported 11-15 years, and six reported greater than 15 years of experience.

Among the participants, three reported having 0-5 years of experience in providing STI services, while four reported having 6-10 years of experience. Additionally, four participants stated they have 11-15 years of experience, and five reported having more than 15 years of experience providing STI services.

The responses regarding comfort level with prescribing EPT varied among the six participants with prescriptive authority. One participant strongly disagreed with feeling comfortable prescribing EPT, indicating a lack of confidence in this evidence-based practice. Conversely, one participant reported feeling comfortable, suggesting a moderate confidence level. Four individuals felt extremely comfortable prescribing EPT, reflecting a high confidence level in this practice.

The six clinicians lacking prescriptive authority are designated as enhanced-role registered nurses (ERRNs). These individuals have undergone advanced training, enabling them

to assess, diagnose, and provide treatment to patients within STI clinics under the auspices of standing orders issued by their respective medical directors. However, it's notable that the CDB does not sanction ERRNs to dispense EPT medication and maintains direct oversight of their clinical practice.

Staff member's perceived barriers to EPT uptake included "not within my scope of practice," "I am only consulted occasionally in this clinic, I see less than ten patients a month here," and "We tried this before, and it failed."

Implications for Nursing

Nurse leaders and public health practitioners can leverage the findings of this project to spearhead quality improvement initiatives aimed at enhancing EPT uptake within LHDs. Nursing professionals can play a pivotal role in advancing STI prevention and control efforts by addressing the identified barriers and promoting strategies for the broader adoption of EPT. This project is a blueprint for developing targeted interventions and policy enhancements within healthcare settings to optimize EPT utilization, thereby contributing to improved public health outcomes. Furthermore, nurse practitioners and other healthcare providers can utilize the insights gained from this study to advocate for systemic changes and resource allocation to support the implementation of evidence-based practices like EPT, particularly in underserved communities.

Future initiatives in the realm of nursing practice scholarship could encompass provider education and training initiatives, which are the creation and evaluation of educational programs aimed at healthcare providers to enhance their comprehension and confidence in executing EPT proficiently. The integration of telehealth platforms or mobile applications to streamline the administration of EPT and facilitate seamless communication between healthcare providers and patients is one possible way to include informatics in addressing this issue.

Another future endeavor could include examining patient adherence to EPT guidelines and evaluate clinical outcomes, such as rates of STI recurrence and patient satisfaction. These metrics could assess the effectiveness of EPT implementation methodologies. The recommended endeavors would advance our comprehension of EPT practices and contribute to enhancing strategies for preventing and controlling STIs.

Conclusion

The project reveals that EPT implementation in NC LHDs remains limited, while healthcare providers are generally receptive to integrating EPT into clinical practice. The data underscores the importance of addressing barriers to EPT implementation and promoting provider readiness to enhance EPT utilization in LHDs. Furthermore, it is essential to acknowledge the project's limitations, particularly the sample size and geographic diversity of local health departments.

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