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The challenges of implementing and evaluating prescription expedited partner treatment

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The evaluation of prescription expedited partner treatment (EPT) for persons with *Chlamydia trachomatis* (Ct), in two New York neighborhoods, conducted by Okah et al.[1], demonstrated low uptake of EPT, possible differential uptake by type of EPT (electronic versus paper prescribing), and highlighted the difficulties in evaluating this intervention.[1] This study adds to the sparse literature on the use of prescription EPT versus the more commonly evaluated patient delivered partner treatment (PDPT). The evaluation is highly relevant given that over 75% of Ct infections are diagnosed in settings where prescription EPT is more likely to be used rather than in STD clinics where PDPT is more likely to be used.[2]

Uptake is difficult to measure as there are several individuals who take part in the process: 1) the provider, 2) the index, 3) the partner and, if prescription EPT, 4) the pharmacist. Provider uptake can be low if knowledge about EPT is low, if there are negative attitudes about it, or if there are legal barriers. Research has found that provider and pharmacists knowledge about EPT is indeed generally low, [3, 4] resulting in rates of ever-use among physicians of about 50% and rates of consistent-use which are far lower.[5] While EPT knowledge and use is higher in states where EPT is legal, actual usage remains surprisingly low (20%–50%, depending on the environment).[6, 7] Negative attitudes about EPT can also reduce uptake. In one study of providers to adolescents, some of the most commonly reported concerns by providers were the worry that EPT would create a missed opportunity to counsel partners, concerns that the partner might not get the medicine, or that the partner would not understand adverse events, and an opinion that the provider should obtain parental consent to provide EPT.[6] There is a great need to educate and combat negative attitudes about EPT among providers and pharmacists.

Legal barriers have been greatly diminished since EPT was first recommended by CDC in white paper in 2006 and in the STD treatment guidelines in 2010. EPT is now legal or potentially allowable in all but three states,[8] but each state may have nuances to their regulations that serve as barriers. For example, the New York State guidelines are that a single prescription should not serve for both patient and the partner, though Okah et al. found that index patients who were given one prescription for both the index and the partner(s) may have been 5 times more likely to fill those prescription than persons who

received separate prescriptions for index and partners. It is possible that the use of a single prescription for both index and partner results in more prescriptions for partner treatment being filled because it removes the barriers of co-pay and a trip to the pharmacy for the partner. Restriction on the practice of EPT, beyond legal/illegal status, need more attention.

After the provider and the index accept EPT, there are still more steps for EPT to be accomplished. In a review paper by Schillinger et al. the steps in EPT are described. [5] For PDPT, there are 5 steps including: 1) index treated by provider, 2) provider offers EPT, 3) patient accepts EPT, 4) patient delivers EPT to partner(s), and 5) partner takes medicine. In prescription EPT there are two more steps if the index can fill the script for the partner(s) and three more steps if the partner(s) have to fill the script for themselves. In the latter scenario, burden is placed on the partner to both go to the pharmacists and pay whatever co-pay is necessary or if that partner does not have insurance, pay for the medicine in full cost. This is an important health disparity issue given that youth and ethnic minorities (such as African Americans and Hispanics) have higher rates of chlamydia[2] and lower rates of insurance.[9] Regulatory boards and insurance companies should consider allowing the index person to fill the prescription for both himself/herself and for the partner.

The measurement of EPT uptake can be complicated as there are several scenarios where EPT is not relevant, requiring refinement of the measure. For example, EPT would not be necessary if the partner accompanies the index to the clinic (and would, therefore, receive treatment) or if the partner was already treated elsewhere (for example the partner was actually the index patient). EPT would also not be possible if the index no longer can or wishes to contact the partner. One study in New York found that while only 55% accepted EPT, 81% of those who refused did so because the partner had already been treated or they were no longer able to contact the partner, thus in reality EPT acceptance was much higher. [10] The wide variability of acceptance rates reported in the literature may be attributed to dilution of the denominator by ineligible. Uptake measures should remove the ineligible from the denominator or clearly define the eligible population.

Measurement of prescription EPT completion is also challenging. This is largely because there is no interaction with the partners and, therefore must rely on index report of partner treatment. In addition, index and partners may have different insurance coverage or may prefer to fill prescriptions at different pharmacies making tracking of filled prescriptions difficult to do. In general, index patients who receive EPT report giving the intervention to their partners, irrespective of if it is PDPT or prescription.[11] But whether or not the partner who receives a prescription rather than the medicine actually gets the medicine is less clear. Medication delivery rates, and presumably treatment rates for PDPT are usually over 70%. [5] The few studies that have evaluated prescription EPT have demonstrated lower prescription fill rates, and presumably treatment ranging from 9% for paper prescriptions the partner must fill[1] to 52% for electronic prescription bundling index and partner(s) treatment[1] to 80% for partner prescriptions filled by the index to 74% for partner prescriptions filled by the partner.[11] Like uptake rates, treatment completion rates should be derived with denominators of only the partners who are eligible to get EPT (i.e. removing those who have already been treated and those who the index partner was not going to contact) and should consider who is filling the prescription.

Prescription EPT is an essential tool for the prevention of repeat chlamydia, yet uptake of EPT and partner treatment completion appear suboptimal. Education of providers and pharmacists is still needed. More permissive laws and insurance policy that allow for the index patient to fill the prescription for himself/herself and the partner(s) may be the key to assuring more partners are treated. More translational research is needed, especially in rural areas, where EPT may be even more important because of greater distance to health care facilities. The study by Okah et al. is a great start to translational research for prescription EPT.

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