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Expedited Partner Therapy for STDs: Legal and Clinical Factors

## WHAT IS THE CURRENT LEGAL SITUATION FOR PHYSICIANS PROVIDING EXPEDITED PARTNER'S THERAPY?

**Our presidential elections is only days away, 48 million people in America are uninsured and healthcare costs are rising 2 to 3 times faster than our nation's GDP. Wherever America's healthcare system be in 5 years, welcome to ReachMD's monthly series focus On Public Health Policy. This month, we explore the many questions facing healthcare today.**

**You are listening to ReachMD XM 157, The Channel for Medical Professional. The centers for disease control had suggested that expedited partner therapy for those with certain conditions such as sexually transmitted diseases, is recommended; however, the active providing medications or prescriptions without an exam or established relationship, faces legal questions for physicians. What is the current legal situation for physicians providing expedited partner's therapy? Welcome to The Clinician's Roundtable. I am Dr. Kathleen Margolin and joining me from Baltimore, Maryland is a tourney, James Hodge and joining us from Seattle, Washington is Dr. Mathew Golden. Mr. Hodge is with the center for lost in the public healthcare, Johns Hopkins Bloomberg for public health and Dr. Golden is an associate professor of medicine at University of Washington School of Washington. He is also a Director of the STD control program for public health in Seattle in King County in Washington**.

**DR. MARGOLIN**:

Welcome, James Hodge and Dr. Mathew Golden.

**DR. HODGE AND DR. GOLDEN**:

Thank you. Thank you.

**DR. MARGOLIN**:

James Hodge, you recently had an article published in the journal of public health describing the legal concerns of expedited partner therapy. You look at 3 areas of relevance when examining legal status in each state. Tell us what the areas of relevance were?

**DR. HODGE**:

You know, that's a great question as far as cannot really assessed whether expedited partner therapy is going to be legally viable in

some jurisdictions. They really are 3 major issues and the first relates to whether or not EPT is consistent with existing medical standard policy for the provision of care and under these circumstances, you really have to ask is there something about EPT, which involves the deliverance of a prescription medication to a person who has not been clinically evaluated as to the what extent and to whether or not that would be consistent with medical practice. EPT raises the spectra that is not consistent with medical practice and as a result could not be done without violating the principles or ethics thereof otherwise. The second big issue really concern the sort of public health or safety side of the condition itself. There are public health justifications for various different mechanisms that we may allow that are somewhat inconsistent with standard day-to-day practice and medical care deliverance and the extent to which EPT works as a very effective public health intervention, may justify its use in certain situations depending on how safely I will use that. You know, there is a whole package of issues related to pharmaceutical practice. Under what circumstances even if EPT is allowable with the medical practice and consistent with good public health, could pharmacist and other professionals of that nature actually participate with EPT without violating drugs, labor and practices, or other dispensing goods. Also, some of the major issues involved with this particular concern.

**DR. MARGOLIN**:

How was the US divided in terms of permission or preclusion of expedited partner therapy?

**DR. HODGE**:

Well, one of the thing that we really tried to work very closely with the Centers For Disease Control And Prevention and host of state partners on is to really to try to get very close to understanding is this practice of EPT is nationally recommended, which it has been by CDC. Is it legally viable in jurisdiction? Here, there is a perception and actually Dr. Golden on the call here has done some excellent work to show that the perception of EPT is that it is not legally permissible. That doctors and others really don't perceive it as a legally viable or sound practice. We have looked very closely at our centers for allowing the public health at the existing legal environment in every state and Puerto Rico and other jurisdictions like Washington DC. What we found in our study that was published in February 2008, was that, you know, approximately 75% of the jurisdictions that we looked at, which is across the United States either directly allow for EPT or could potentially allow for based on the review of the legal provisions that we were seeing. This really kind of turned the perceptions on their head. In reality, EPT may be possible to do without violating legal norms in a lot of jurisdiction, only about 15 jurisdictions or so actually prohibited based on what we saw in this table.

**DR. MARGOLIN**:

Dr. Golden, what is your assessment of how physicians feel about expedited partner therapy?

**DR. GOLDEN**:

I think there is probably a lot of confusion about what is going on. I think, you know, otherwise we as public health officials need to make it clear to people. I think, the other things that I have pointed out that James was commenting on, this is really a moving target. So, as you know James published this paper in the last year, but since he has published that paper, it has become clear that this is legal in places like Texas and New York as well. So, we are really moving very, very quickly to a point where it is becoming legal in more and more jurisdictions around the country.

**DR. MARGOLIN**:

In the article and obviously you just stated that it has changed since the article was published, but when the article was published it states that only 4 states have by large expressly endorsing expedited partner therapy and then some other states were mentioned that have proposed similar legislation, but the legislation didn't pass. Why would that happen? What stops this kind of legislation from passing?

**DR. HODGE**:

Well, this type of legislation is the type that may not get sufficient attention in any given state. This is the process we go through the past various different public health legislation, consistent with, for example, authorizing EPT in an express sort of way. May not get the sort of attention that the legislative boney may find compelling for a particular cycle. It simply may just get pushed aside in a particular legislative that's largely been what I have seen in a couple of the states that we found it was introduced and not fully passed. Just as, Mathew was mentioning though, in our study a few months dated now, that was legislation introduced in New York. It was not passed, but now that legislation just recently has been passed in the recent cycle. I think, what you are seeing at least in some jurisdictions, is just a non-appreciation of the value of the particular legislation at a given time, what you are not seeing in too many jurisdictions, is just real resistance or active objection to the idea of allowing for expedited partner therapies as good public health policy. I think, Mathew is right. It is starting to take hold of the United States and more states are actually especially authorizing it, fewer states are, in anyway, shaping for trying to prohibit it.

**DR. GOLDEN:**

Well I think, part of what the opposition come from is, you know, there is a little bit of the enemy that good is the best and this notion what shouldn't the health department just provide complete partner identification services for everybody. I mean, why don't we just have people from the health department contact everybody with a reportable sexually transmitted disease and have them go find those people's sex partners and get them treated and I can understand where that comes from? The problem with it is that the CDC, control budget for the country is 107 million dollars and to just hire the staff to do what is being proposed, we have estimated it may would cost 200 million dollars, so we would need twice as big a budget just for that 1 activity than the country has for the entire area of sexually transmitted disease control at least within the federal budget. So, its really simply not possible to use, you know, this traditional syphilis based approach to most aggressive partner identification like what is done in Sweden.

**DR. MARGOLIN**:

Wouldn't it be more cost effective and more timely to try to pass some federal legislation that is similar to the kind of legislation that you have in Washington?

**DR. GOLDEN**:

I will defer to James to that. I think this is something, which is more regulated at a state level than a federal level, but James is more knowledgeable than I am about that.

**DR. HODGE**:

Yaa, Mathew that's exactly right. You know, the federal government through CDC and through other public health agencies within the

department health and services is well equipped to address a lot of concerns in public health, but the true reality of public health legislation and regulation in the United States that this is state base material. States are in control of how public health is practice on a state by state basis and as a result you would not very likely see this type of issue ever arising at federal piece of legislation, nor would CDC or others be well situated to actually implement it what would help as Mathew has mentioned if this congress would provide more significant funding for STD control, that would certainly make a big difference.

**DR. MARGOLIN**:

Until, all of the states catch up, Dr. Golden what will be your advice to physicians where expedited partner therapy is currently prohibited. What will be your advice to them in order to help them promote face to face treatment for the partners of those infected with sexually transmitted diseases?

**DR. GOLDEN**:

Well, I think that they need to follow up with their patients about whether or not their partners are got treated. So, our first step would be to say it isn't enough to simply say, so you need to get your partner treated and then that's the end of discussion and may be one way to integrate this with the patient's care is there is no group you can identify that has a higher risk of bacterial sexually transmitted disease than people who just had one. So, bad things happen to people who have bad things happened to them in this world and that's true of everything in medicine, whether its heart attack, cancer, or sexually transmitted diseases. So, if we routinely follow up with our patients to make sure they get retested say 10 to 18 weeks out. Part of that routine followup can also be being certain that partners have been treated.

**DR. MARGOLIN**:

Mr. Hodge, if the physician wants to know what the current status of legality of expedited partner therapy is in his/her state, where should they look for answers?

**DR. GOLDEN**:

Well, this is very good information available in CDC web site that is actually based on the work we have done closely with CDC in the last couple of years. There is a very nice web page entitled legal status of expedited partner therapy on CDC websites that if you could Google it, you will find it quite easily, but most importantly one of things you have to really be (10:09) conscientious of, the type of information that you will find there is not providing specific legal advice rather it is providing the type of legal resources and research that we have done in an academic environment and the CDC posters online to at least help your attorney or your hospital counselor whoever you are really working with, really asses whether its permitted or prohibited in your specific jurisdiction. Based on my review of what I have seen looking collectively at all the laws across the nation under the various teams, I do see opportunity for EPT to be accomplished and one in a lot of jurisdiction, very few actually were direct prohibited.

**DR. MARGOLIN**:

Something that, we haven't address so far, is health insurance and the complications that might arise from expedited partner therapy as people tried to make claims for medicine for example?

**DR. GOLDEN**:

This is something actually that I addressed in the article in AJPH because its one of those issues that really comes up. You know, the treatment for the specific STDs is not very expensive, it's really quite minimally frankly. However, when you are talking about potentially thousands of cases that might filter through to a single insurance company, certainly larger ones <_____>. They could raise issues about who is actually going to pay for the dosage for the partner who is not actually the patient and that means not actually the insured. Well, this issue it really should not come up for a couple of reasons, first, it is to the patient's significant benefit to have the partner treated. In other words, the patient's health is directly tied to the partner's health. I think, that's what Mathew was just suggesting and that's exactly what you see with EPT. The second reason is that this is just a good investment for insurance company. Making this additional investment for the patient to treat the partner, is going to help the patient's health overall and we are talking about very minimal cost in most cases. Still, even in states like California, which expressly authorize EPT, you do see resistance among the California version of Medicaid that would resist payment for that second dosage.

**DR. MARGOLIN**:

I would like to thank my guest, Dr. Mathew Golden and Dr. James Hodge.

**DR. HODGE AND DR. GOLDEN**:

Thank you. Thanks.

**I am Dr. Kathleen Margolin. You have been listening to a special segment, Focus on Healthcare policy on ReachMD XM 157, The Channel for Medical Professionals. Be sure to visit our web site at www.reachmd.com featuring on-demand pod casts of our entire library. For comments and questions, please call us toll free at 888-MD XM 157 and thank you for listening.**

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