Current practices and perspectives of women's health providers on STI treatment of sexual partners

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Aggressive medical management of sexual partners has been demonstrated to decrease rates of sexually transmitted infection (STI), including rates of reinfection.[1] Partner management has traditionally been through referral for treatment. The healthcare provider (HCP) advises the index patient to inform their partner of their STI diagnosis and encourage them to seek treatment at a local clinic or with their own HCP. Advantages to seeing the partner for treatment at the same clinic as the index patient include the opportunity for quicker treatment and the ability for the HCP to be better assured that the partner(s) did receive treatment.

Expedited partner therapy (EPT) has been established as an effective method of treatment that does not require the partner to be seen by an HCP. With EPT, the index patient is provided with medication or a prescription that

they deliver directly to their sexual partners.[2] The Centers for Disease Control and Prevention (CDC) recommends EPT as a useful option for partner management, particularly for the treatment of chlamydia and gonorrhea.[3] The legal status of EPT varies from state to state. See the link to the CDC page on this status: cdc.gov/std/ept/legal/default.htm.[A]

There remain flaws with all of these methods, in that the index patient may not inform their partner and partners may refuse treatment. Some literature analyses have suggested that EPT paired with partner referral may create an optimal method of partner management.[3–5] The purpose of this study was to examine HCP use of a new partner treatment policy 2 years after implementation and to identify HCP perceived barriers to offering partner treatment.

Partner treatment policy

In 2015, a new partner treatment policy was introduced at the outpatient clinics of a tertiary women's health center in Western Pennsylvania. Prior to the initiation of this policy, index patients were advised to have their partners seek treatment with other HCPs. The new policy allowed for treatment of sexual partners at any of the outpatient women's health center clinics. With this policy, a patient who tested positive for chlamydia, gonorrhea, or trichomonas was advised to notify partners and encourage them to call the outpatient clinic for an appointment. These appointments consisted of a brief patient interview by an HCP, testing for STIs, and treatment based on the index patient's diagnoses. The new policy did not support the use of EPT, although legal in Pennsylvania, because of concerns about state guidelines the institution believed were unclear.

Methodology

Sample

A convenience sample of 96 providers who staffed the outpatient clinics was used for the study. All of the potential participants regularly diagnosed and treated women for STIs.

Procedure

A descriptive survey was developed to assess providers' current partner treatment practices and any perceived barriers they had to offering partner treatment. Content of the survey was based on an extensive literature review of treatment of sexual partners and provider barriers to offering partner treatment.[6–9] To establish content validity, two women's health experts and a statistician reviewed the survey. The survey consisted of nine yes/no questions that assessed provider's knowledge of the clinic's partner treatment policy, state legal regulations for EPT, and their own partner treatment practices.

Participants rated professional liability as the most common perceived barrier, with 63% agreeing or strongly agreeing that it was a barrier to providing partner treatment.

Next, the survey listed nine commonly cited barriers to providing partner treatment. Using a 5-point Likert type scale that ranged from strongly agree to strongly disagree, participants were asked to rank impact of the barriers to their practice habits. Surveys were e-mailed to the potential participants. All responses were anonymous. The Institutional Review Board for Robert Morris University and the Quality Improvement Research Council for the healthcare facility where this study took place reviewed and approved this project. Data were analyzed using descriptive statistics.

Results

Of the surveyed providers, 28 completed and returned the survey, for a return rate of 29%. The participants were mostly attending physicians (61%). They were also nurse midwives (14%), resident physicians (8%), nurse practitioners (3%), and physician assistants (3%). Half (50%; n = 14) of the participants were aware of the new partner treatment policy. Less than one-fourth (21%; n = 6) of the participants stated they used the policy. The most common method utilized for the management of sexual partners was referral to a local STI clinic (68%; n = 19).

Participants rated professional liability as the most common perceived barrier, with 63% agreeing or strongly agreeing that it was a barrier to providing partner treatment. Lack of understanding of state legal guidelines on partner treatment (54%) and lack of knowledge of institutional guidelines on EPT (52%) were also identified as significant barriers. A full breakdown of responses to perceived barriers can be viewed in the *Table*.

Discussion

The intention of this study was to analyze a recently implemented partner STI treatment policy at an outpatient women's health center. Approximately half of participants reported knowledge of the recently introduced policy. Less than half of the participants who were knowledgeable of the policy utilized it.

Following completion of this study, a discussion was held between the principal investigator and clinic administration. The study demonstrated a lack of knowledge of clinic policies and procedures on partner treatment. With the intent to bolster current policy utilization, this policy is now included in new provider orientation and resident training programs. Clinic administration has continued to

Table. Perceived barriers to offering partner treatment

	Strongly disagree/ disagree	Slightly agree	Agree/ strongly agree	Total
Lack of training on discussing partner notification of STIs with patients	12 (48%)	3 (12%)	10 (40%)	25
Safety concerns for my patient (eg, possibility of intimate partner violence)	7 (26%)	9 (33%)	11 (41%)	27
Professional liability for treating sexual partners	7 (26%)	3 (11%)	17 (63%)	27
Not having enough time with patients to adequately discuss partner treatment	11 (42%)	8 (31%)	7 (27%)	26
Not being able to treat all of my patient's partners	11 (42%)	5 (19%)	10 (39%)	26
My personal beliefs to offering partner treatment	21 (84%)	0 (0%)	4 (16%)	25
Lack of knowledge of my institution's partner treatment guidelines	9 (36%)	4 (16%)	12 (48%)	25
Lack of knowledge of my institution's stance on EPT	7 (28%)	5 (20%)	13 (52%)	25
Lack of understanding the legal guidelines of my state on partner treatment	4 (16%)	8 (31%)	14 (54%)	26

EPT, expedited partner therapy; STI, sexually transmitted infection.

discuss partner notification and treatment practices with providers and residents as they begin their orientation or rotations. Additionally, education now includes the nurses at the clinic, as it is often their responsibility to communicate positive STI test results to patients and to discuss partner treatment. Assessing the use of this policy will be an ongoing process for the administrative staff at this clinic, and no major changes were made to the policy following this study.

In this study, provider liability was listed as the top perceived barrier to offering partner treatment. Concerns with liability could be related to confusion surrounding institutional and state policies, which are listed as barriers in previous studies.[6,10,11]

The clinic where this project took place did not support the use of EPT. Unfortunately, states where EPT is considered legally permissible often have some level of legal barriers that prevent full utilization. EPT is a CDC-endorsed treatment strategy, but providers need to be aware of policy and procedure at both the institutional and state level where one practices. Deviating from established policies could cause untoward legal ramifications.

Limitations

The study was conducted at one outpatient clinic with a small convenience sample of providers and thus the results may not be generalizable. Only 29% of providers responded to the survey, a small response rate but not unexpected with a digital survey methodology.

Conclusion

Staff education is key to successfully implementing a new policy. As staff at this clinic receive more education on this policy, hopefully better application of it in everyday practice will occur. The clinic did not support routine use of EPT. Advocacy could lead to better state laws, possibly allowing providers at this clinic to increase its use. Analysis of this partner treatment policy will be an ongoing process.

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Web resource

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