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Subject:
Date: February 8, 2024 at 3:08 PM
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02/08/24

To the House Health and Human Services Committee
Re: HB 2750
Chair Landwehr
Committee Assistant David Long

From: Karen “Kelly” Fritz, APRN, CNM
Proponent of Expedited Partner Therapy
Volunteer at Miami County Health Department, Women’s Clinic
In-person testimony for 2/12/24.

Thank you to Chair Landwehr for holding this meeting and addressing the topic of Expedited Partner Therapy, HB 2750. Thank you for the opportunity to speak.

I am an APRN, Certified Nurse Midwife (CNM), and have worked with women and babies for 39 years, first as a nurse, then as a Clinical Nurse Specialist in Women’s Health and Community Health, and for the past 21 years as a nurse midwife. One of the hallmarks of nurse midwifery is listening to women. My career has been characterized by listening to and serving women in their healthcare. I am here to speak for the Kansas women.

I have volunteered at the Miami County Health Department for the past 18 years, first in their Family Planning Clinic, and now in a limited scope Women’s Health Clinic, two mornings a month.

I fully support Expedited Partner Therapy as a tool to target and treat sexually transmitted infections (STIs). EPT is an Evidence-Based practice, following National Guidelines (CDC), and professional Standards of Care. EPT is supported by the American College of Nurse-Midwives (ACNM), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP).

The physicians I have worked for and collaborated with have supported me in utilizing EPT for my clients’ partners. They do it themselves. There have been no adverse reactions or complications from utilizing EPT in any of the practices I have worked.

EPT is managed by treatment regimens provided by the CDC, and is recommended to be offered to patients when the provider cannot ensure that all of a patient’s sex partners from the previous 60 days can or will seek timely treatment. Providing packaged oral medication (as at the Health Department) is preferred because many obstacles can exist at the pharmacy level, and many persons do not fill the prescriptions provided to them by a partner. At the health department, education and instructions are provided.

My goal is to increase opportunity for testing, treatment and health in the women of my community. EPT is something that can help reduce reinfection in my clients from their partners.

We know that women are more likely to be screened and tested. We are accustomed to getting annual exam visits for renewal of prescription birth control, for periodic cervical cancer screenings, so are more likely to have an appointment which may include STI screening. Women also receive routine STI screenings during prenatal care, due to the risks to the mom, pregnancy and fetus. Women who screen positive are treated and recommended follow-up testing. **Treatment of partners is crucial in decreasing re-infection.**

Young men are not accustomed to having annual exams unless they are on prescription medication and therefore do not have the same opportunity for routine screenings. They are also less likely to have an established relationship with a healthcare provider. My female clients have reported that their partners either initially deny they could even have an infection because they are asymptomatic, are hesitant to find or see a new healthcare provider, are afraid they will be “swabbed”, don’t have health insurance, or can’t afford a doctor’s visit. These barriers to care make it “unlikely” for timely testing and treatment of partners. Clients and partners ideally are treated and abstinent at the same time, to decrease risk of reinfection. **EPT can bypass those barriers, leading to immediate and concurrent treatment, and decrease the spread of infection to others.**

In Miami County:

We have no obstetricians, gynecologists, CNMs providing maternity care, nor anywhere to go to have a baby. **Lack of providers for women's health is a barrier to routine care and testing in Kansas.**

We have no Family Planning Grant, which would provide free to low cost services. We only have my limited Women's Clinic, which is not free, because we have no Grant funding. Attendance at this clinic is far below attendance prior to the loss of the grant. **Cost is a barrier to routine care and testing.**

There are no OB-GYN/midwifery practices or places to deliver a baby from Overland Park (Johnson County) to Pittsburg (Crawford County). Women in Miami County, Linn County, Bourbon County and Anderson County have no locally based OB-Gyn/Midwifery practices, and limited Family Planning Grant programs. **Distance to services and cost of travel is a barrier to care and testing.**
My county is not alone in this. 75% of Kansas counties have no maternity care services. **No maternity services is a barrier to routine care, testing and treatment.**

The data that we have is concerning (see Miami County Data), but incomplete. **Local and systemic barriers to routine care and testing** mean that there are more cases out there than we know, so we need to treat partners to try to have an impact.
March 2020-Summer 2022 **Covid decreased attendance to all healthcare appts**, limiting opportunities for testing, and we are still catching up on some of those services/screenings.

Fewer people today have long term, established relationships with a provider or provider office than in the past. My family went to one family practice doctor for 27 years. Today providers change employment, practice locations or insurance networks more frequently. Today individuals may change insurance companies frequently, affecting their available in-network provider options and continuity of care.

Try anonymously calling a few private offices this afternoon and ask about their first available new patient appointment. I tried that last week for a pregnant woman at 20weeks with no prior prenatal care, and the answer was April 5th (two months out).
These are all barriers to care, testing, treatment, and public health.

In the face of all these barriers to care, Expedited Partner Therapy can help us have an impact on the increasing number of newly identified STI cases by reducing ongoing transmission of the infection and preventing re-infection of the original patient.

Thank you.

Miami County Information

This data is released from **KDHE's STI/HIV Surveillance Program** directly to local health departments; therefore, this information is sensitive, and caution needs to be used when releasing data that may be identifiable.
Due to the information being sensitive and possibly identifiable, there are a few categories that have been combined to prevent a breach of HIPPA.
These cases may have resulted from tests completed in county or out of county. Many pregnancies are cared for out of county, and those positive screenings are included in these numbers.

Miami County Disease Count Cases 2018:
- Chlamydia: 101
- Gonorrhea: 23
- Primary Syphilis, Secondary Syphilis, Early Latent Syphilis, Late Latent Syphilis and HIV: 1

Miami County Disease Count Cases 2019:
- Chlamydia: 88
- Gonorrhea: 15
- Primary Syphilis, Secondary Syphilis, Early Latent Syphilis, Late Latent Syphilis and HIV: 4

Miami County Disease Count Cases 2020:
- Chlamydia: 94
- Gonorrhea: 21
- Primary Syphilis, Secondary Syphilis, Early Latent Syphilis, Late Latent Syphilis and HIV: 2

Miami County Disease Count Cases 2021:
- Chlamydia: 107
- Gonorrhea: 21
- Primary Syphilis, Secondary Syphilis, Early Latent Syphilis, Late Latent Syphilis and HIV: 5

Miami County Disease Count Cases 2022:
- Chlamydia: 89
- Gonorrhea: 29
- Primary Syphilis, Secondary Syphilis, Early Latent Syphilis, Late Latent Syphilis and HIV: 2

Miami County Disease Count Cases 2023:
- Chlamydia: 89
- Gonorrhea: 19
- Primary Syphilis, Secondary Syphilis, Early Latent Syphilis, Late Latent Syphilis and HIV: 4

In September 2022, the **Miami County Health Department** partnered with a local APRN-FNP to start offering STD testing and treatment to the community (both males and females). MCHD also partnered with a laboratory to provide lower cost lab tests beyond those provided by KDHE.

From September 2022 through the year of 2023, MCHD ran 40 "full panel" STD test, to include Gonorrhea, Chlamydia, HIV, Syphilis and Hepatitis B and C.

From September 2022 through the year of 2023, MCHD conducted 23 Gonorrhea and Chlamydia only test, and 2 miscellaneous tests, for a total of 65 tests conducted.

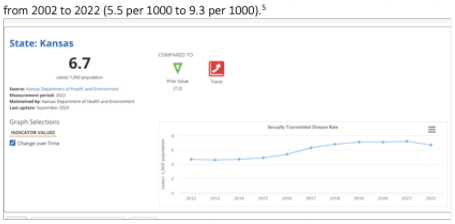
What is Expedited Partner Therapy?

Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner.[1]

One of the most common scenarios for EPT is when a female Kansan seeks medical treatment for a STI, but she has a male partner who refuses to go to the doctor. Empowering her with the ability to provide a prescription to her partner can save her from becoming reinfected in the future.

Why Is EPT Needed in Kansas?

- The ability to treat sexual partners is important given that up to 14 percent of people with chlamydia and 12 percent of people with gonorrhea become reinfected within 12 months of treatment, often through untreated partners.[2]
- STIs can cause premature labor, which is the number one cause of infant death and can lead to long-term developmental and health problems in children.[3]
- Both gonorrhea and chlamydia can pass from the mother to her baby as the baby passes through the birth canal. [3]
- Untreated gonorrhea and chlamydia can lead to pelvic inflammatory disease and infertility. [4]
- STI rates in Kansas have increased significantly over the past decade, nearly doubling from 2002 to 2022 (5.5 per 1000 to 9.3 per 1000).[5]



- STI rates in Miami County have increased 195% since 2002 (1.9 per 1000 to 3.7 per 1000).[6]

POSITION STATEMENT

Expedited Partner Therapy to Treat Sexually Transmitted Infections

The American College of Nurse-Midwives (ACNM) affirms the following:

- Expedited partner therapy should be used to treat sexually transmitted infections (STIs) based on the current clinical guidelines from the Centers for Disease Control and Prevention.[1]
- The provision of expedited partner therapy to treat STIs is within the core competencies for midwifery care and the scope of clinical midwifery practice, whereas general care for men is not.[2]
- ACNM members should advocate for the legalization of expedited partner therapy in all states to improve access to care and reduce the incidence of STIs.

Background

Sexually transmitted infections present a substantial public health challenge. Rates of STIs have been steadily increasing for the past 3 years.[1] From 2015 to 2016, there was an increase in all 3 reportable STIs: 4.7% increase in cases of chlamydia, 18.5% increase in cases of gonorrhea, and 17.5% increase in cases of syphilis. Women are more significantly affected than men, and when left untreated in women, STIs can lead to infertility, life-threatening ectopic pregnancy, and an increased risk for HIV transmission and infection.[1] Certain infections can be transmitted from the pregnant woman to the fetus, which may result in congenital anomalies, neonatal morbidity, spontaneous abortion, or fetal demise.

Comprehensive care for women with STIs includes treatment of partners to decrease the risk of reinfection. Through expedited partner therapy (EPT), a woman is given medications or prescriptions for her sexual partner(s), who does not need to be examined by a health care provider.[3] Evidence indicates that patients whose partners received EPT were 29% less likely to be reinfected than those who were simply told their partners needed to visit health care providers for treatment.[3]

Regulations for EPT vary from state to state, and the practice is currently legal in 41 states, potentially allowable in 7 states, and prohibited in 2 states. In states in which EPT is legal, treatment rates are higher than in states where it is not.[3] Advocacy efforts to increase the number of states that allow EPT have the potential to reduce the disease burden for the community and morbidity rates related to untreated STIs for adults, adolescents, and newborns.

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INTERIM UPDATE

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 737 • June 2018

(Replaces Committee Opinion Number 632, June 2015)

Committee on Gynecologic Practice
Committee on Adolescent Health Care

INTERIM UPDATE: This Committee Opinion is updated as highlighted to reflect newer guidance from the Centers for Disease Control and Prevention regarding the potential role for expedited partner therapy in the management of trichomoniasis.

Expedited Partner Therapy

ABSTRACT: Sexually transmitted infections (STIs) disproportionately affect women and create a preventable threat to their fertility. One factor that contributes to young women's high rates of STIs is reinfection from an untreated sexual partner. One way to address this problem is through expedited partner therapy, the practice of treating the sexual partners of patients in whom STIs are diagnosed. Expedited partner therapy enables the obstetrician–gynecologist or other provider to give prescriptions or medications to patients to take to their partners without first examining these partners. Despite the effectiveness of expedited partner therapy, numerous legal, medical, practical, and administrative barriers hinder its routine use by obstetrician–gynecologists. The American College of Obstetricians and Gynecologists supports the use of expedited partner therapy as a method of preventing gonorrhea and chlamydial reinfection when a patient's partners are unable or unwilling to seek medical care. Expedited partner therapy should be accompanied by patient counseling and written treatment instructions for the patient's partner(s). Partners receiving expedited partner therapy should be encouraged to seek additional medical evaluation as soon as possible to discuss screening for other STIs, including human immunodeficiency virus (HIV) infection.

Conclusions and Recommendations

The American College of Obstetricians and Gynecologists (the College) makes the following conclusions and recommendations:

- The College supports the use of expedited partner therapy as a method of preventing gonorrhea and chlamydial reinfection when a patient's partners are unable or unwilling to seek medical care.
- The College encourages members to advocate for the legalization of expedited partner therapy and to work with their health departments to develop protocols for its use.
- Partners receiving expedited partner therapy should be encouraged to seek additional medical evaluation as soon as possible to discuss screening for other sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) infection.
- Expedited partner therapy is recommended only after an obstetrician–gynecologist or other provider has assessed the risk of intimate partner violence associated with partner notification. It is not intended for use in cases of suspected child abuse, sexual assault, or any other situation in which the patient's safety from her abuser may be compromised.

Background

Sexually transmitted infections disproportionately affect women and create a preventable threat to their fertility. In the United States, adolescent girls and young women aged 15–24 years consistently have the highest number of cases of gonorrhea and chlamydial infection (1). One factor that contributes to young women's high rates of STIs is reinfection from an untreated sexual partner. One way to address this problem is through expedited partner therapy, the practice of treating the sexual partners of patients in whom STIs are diagnosed. Expedited partner therapy enables the obstetrician–gynecologist or other provider to give prescriptions or