



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

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Testimony in Support of HB 4736 (S-1) to Permit Expedited Partner Therapy (EPT)
Senate Health Policy Committee
May 28, 2014

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Thank you for taking-up this important public health issue, which is especially important for women's health. The Administration fully supports House Bill 4736 (S-1), which would authorize health professionals to provide Expedited Partner Therapy (EPT). This 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 or her partner without the health care provider first examining the partner.

Sexually transmitted infections are a significant public health problem in Michigan and across the United States. Every year gonorrhea and chlamydia are the most frequently reported infections. In 2013, there were 10,698 cases of gonorrhea and 44,796 cases of chlamydia reported in Michigan. In your packet, you will find data that shows how your individual districts are impacted by these infections.

EPT is a proven effective intervention that is highly recommended by the Centers for Disease Control and Prevention (CDC). It is endorsed by the American Congress of Obstetricians and Gynecologists, the American Medical Association, the American Bar Association, the American Academy of Pediatrics, and the Society for Adolescent Health and Medicine. Currently, Michigan is one of only six states where the practice of EPT is legally prohibited.

Treating partners of individuals with a sexually transmitted infection without a confirmed laboratory result (known as presumptive treatment) has been a standard of care in clinical settings for decades. For infections such as chlamydia and gonorrhea, which are largely asymptomatic and highly infectious, it is imperative that individuals who are infected or who are at increased risk for infection due to exposure are treated quickly to halt the spread to others.

The immediate benefits of EPT are significant. Studies have shown that it reduces the amount of re-infection by approximately 24 percent. Assuring timely treatment of partners avoids negative health outcomes for the partners as well as subsequent transmission from these untreated cases. In addition, avoiding re-infection and untreated infection results in fewer negative health outcomes for young women, such as Pelvic Inflammatory Disease, ectopic pregnancy, infertility, and increased risk of HIV.

In this time of shrinking resources, it is also important to acknowledge the fiscal benefits of EPT. As a result of lower re-infection rates and partners being treated outside of a clinical setting, there is reduced burden on public health clinics as well as private physicians, emergency departments, and other health centers, as there are fewer patient visits needed to manage these diseases.

In recent years the State STD Program, along with our local health partners, have been forced to make difficult decisions in the face of declining resources. In an ideal situation, every case of reported chlamydia and gonorrhea would be provided individual case management services, including the notification and referral of sexual partners. However, today's public health system does not have the capacity to do this for all of the 60,000 plus reported cases of these infections each year.

Finally, it is important to stress that EPT is safe. We are fortunate that there are effective single-dose oral therapies available to treat these infections. Time has shown that the only side effect is mild nausea and it rarely occurs. California, the first state to adopt EPT in 2001, established a dedicated hotline to track adverse reactions. However, after ten years without a single report, the hotline was shut-down.

EPT provides clinicians with another tool to treat these infections. The department stands ready to assist in the development of the patient information sheet and other educational materials to implement this new law.

Thank you.

Why is Expedited Partner Therapy (EPT) a Michigan Issue?

EPT is Needed:

Chlamydia and gonorrhea are the #1 and #2 most reported infections in Michigan every year, affecting every county in the State. In 2012, 48,727 new cases of chlamydia and 12,770 cases of gonorrhea were reported.

EPT is a proven effective method to intervene in the spread of gonorrhea and chlamydia. Studies estimate that it reduces re-infection rates by up to 30%.

EPT is intended to be a single tool in a larger menu of options to manage partners of individuals diagnosed with gonorrhea and chlamydia. As public health resources have declined in recent years, it is critical that we provide clinicians with effective options to manage their client's long term health.



EPT is Safe:

Drugs used are single dose therapy and highly effective with minimal risk of side effects.

California has used EPT for over a decade. They had a dedicated hotline for reports of adverse reactions; it was recently shut down as there were zero reports in 11 years.

Experts state that there is no risk of EPT causing population level resistance. Azithromycin, used to treat chlamydia as well as part of dual therapy for gonorrhea, is also used to treat many other conditions. Even if EPT was used on all 3 million CT cases reported annually, it would only increase the overall use of this drug by <5%.

Recent reports of risks associated with Azithromycin do not apply to the use of this drug in the treatment of chlamydia or gonorrhea. This is a widely used drug. Studies that linked Azithromycin to health risks examined a 5 day regimen, not the single dose used to treat these infections.

In states where EPT is used, there is no evidence of drugs used for EPT being part of the "black market".

EPT is Cost Effective:

Traditional partner management is a costly intervention requiring extensive effort and work hours by local health department Disease Intervention Specialists and/or medical staff to locate and assure evaluation and treatment for partners.

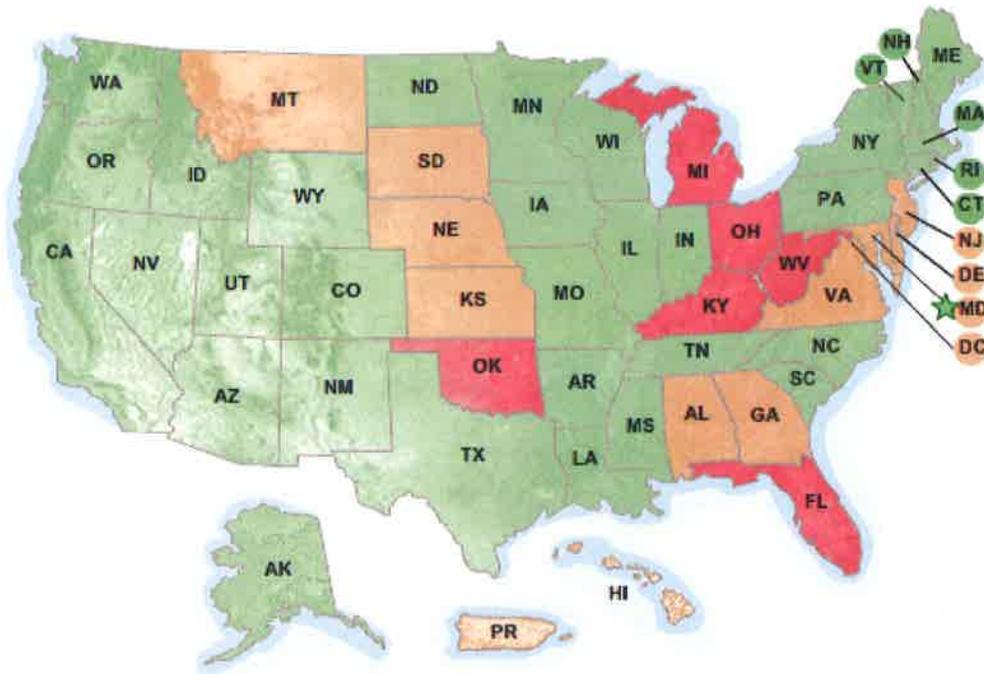
Each partner treated via EPT saves a clinic/office appointment for another individual – this is significant with diminished access to local health clinics. Additionally, it saves the cost of performing testing on the partner, currently \$77.08 at the MDCH laboratory.

Research estimates 40% of untreated females develop Pelvic Inflammatory Disease. Each case of untreated infection that leads to PID costs almost \$4,000 (in 1998 dollars) just in immediate medical costs. Future costs related to infertility, as well as issues such as lost work time, are not calculated.

For additional information,
please contact:

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Legal Status of Expedited Partner Therapy



EPT is permissible in 33 states:	EPT is potentially allowable in 11 states:	EPT is prohibited in 6 states:
<p> Alaska Arizona Arkansas California Colorado Connecticut Idaho Illinois Indiana Iowa Louisiana Maine Massachusetts Minnesota Mississippi Missouri Nevada New Hampshire New Mexico New York North Carolina North Dakota Oregon Pennsylvania Rhode Island South Carolina Tennessee Texas Utah Vermont Washington Wisconsin Wyoming </p> <p> ★ Exception: EPT is permissible in Baltimore, Maryland. </p>	<p> Alabama Delaware Georgia Hawaii Kansas Maryland Montana Nebraska New Jersey South Dakota Virginia </p> <p> EPT is potentially allowable in District of Columbia and Puerto Rico. </p>	<p> Florida Kentucky Michigan Ohio Oklahoma West Virginia </p>



Expedited Partner Therapy: Reducing Health Care Costs and Creating Healthy Communities

What is Expedited Partner Therapy?

- Expedited partner therapy (EPT) is an option for treating the sexually transmitted diseases chlamydia and gonorrhea.
- Typically when a patient tests positive for these sexually transmitted diseases (STDs), they are treated with antibiotics by a clinician. Treatment of the patient's sexual partner(s) is crucial to preventing reinfection of the patient. Conventional methods of ensuring treatment of a patient's sexual partners include:
 1. Direct contact by the clinician with a patient's sexual partner(s);
 2. A patient encouraging his/her partner(s) to visit a clinician; or
 3. A patient providing the name(s) of his/her partner(s) to health workers to contact.¹
- EPT enables healthcare professionals to provide patients with either antibiotics or prescriptions for antibiotics to their sexual partner(s) without a visit by the partner(s) to a health care center.
- EPT's legal status is different in every state. To find out more about your particular state, please visit: www.cdc.gov/std/ept/legal.

Why Use EPT? It Works!

- Traditional sexual partner referral is both a resource and time intensive option for STD control, and is increasingly limited given the decreasing financial and personnel resources in public health programs.
- EPT allows a health care provider to get treatment to a low-income or uninsured individual without a costly office visit or unduly taxing public health department staff.
- EPT is recommended by the Centers for Disease Control and Prevention (CDC).²
- Patients diagnosed with gonorrhea or chlamydia who received EPT were:
 - More likely to report that all of their sexual partners were treated than those who were told to refer their partners for treatment;
 - Less likely to report having sex with an untreated partner; and
 - Less likely to be diagnosed with another infection at a follow-up visit.
- States issue clinical care guidelines specifying the types of patients and antibiotics best suited for EPT through laws and policies.
- EPT is more successful than traditional patient referral approaches in getting antibiotic treatment to sexual partners.²

EPT Success Stories

- In Washington state, currently over one-third of all heterosexuals with chlamydia or gonorrhea receive EPT for their partners, and over half of those using EPT are offered medication.
- In California, nearly half of physicians and nurse practitioners report using EPT. California's partner treatment rate with EPT is 80%-- the same partner treatment rate for those who agreed to bring their partners with them to the clinic.
- In 2001, California was the first state to authorize EPT and after over ten years of use, no adverse effects have been reported.

The Health Burden of Chlamydia and Gonorrhea

- Almost 1.3 million cases of chlamydia and almost 309,000 cases of gonorrhea were reported in the US in 2010.³
- Blacks are 8 times more likely to contract chlamydia compared to whites; Native Americans and Hispanics are 4.3 and 2.7 times more likely, respectively.³
- Blacks are 18.7 times more likely to contract gonorrhea than whites; Native Americans and Hispanics are 4.6 and 2.2 times more likely, respectively.³

EPT Saves States Money!

- An estimated \$850 million is spent annually treating chlamydia and gonorrhea.⁴ EPT can decrease these costs by reducing the spread of infections and reliance on public services to treat STDs.
- If left untreated, chlamydia and gonorrhea can progress to pelvic inflammatory disease (PID) in women, resulting in additional treatment costs of \$1,167 per case of PID.⁵ Both infections are also a common cause of infertility.^{6,7} Because EPT increases STD treatment rates,^{6,7} it may decrease the number of cases of chlamydia and gonorrhea that lead to infertility and PID.
- Both chlamydia and gonorrhea change the immune system and may increase a person's chances of contracting HIV if exposed to the virus.^{8,9} For every HIV infection that is prevented, an estimated \$355,000 is saved in the cost of providing lifetime HIV treatment, resulting in significant cost-savings for the health care system and state coffers.¹⁰ EPT may be an effective HIV prevention tool, and cost saver, because it reduces chlamydia and gonorrhea rates.

What Can State Policymakers Do?

EPT can be a challenging topic since each state has different medical practice laws. In some states, regulations by medical boards prohibit doctors from using EPT. In others, statutes may prevent the practice of EPT. As referred to previously, the CDC's EPT website (www.cdc.gov/std/ept/legal) can help legislators understand the legal landscape in their state. In addition, state policymakers can:

- Learn More – Talk to your state's STD director to discuss if EPT can be implemented in your state and the potential public health impact.
- Educate Others – Talk to other policymakers about how many people are infected with chlamydia and gonorrhea and the consequences of persistent infections.
- Talk to Us – The National Coalition of STD Directors and the Council of State Governments are ready to provide officials with information about EPT and its potential impact on STDs. Contact us at:
 - Burke Hays, State Policy Associate, at the National Coalition of STD Directors (StatePolicy@ncsddc.org 202-842-4660, www.ncsddc.org)
 - Debra Miller, Director of Health Policy, at the Council on State Governments (dmiller@csg.org or 859-244-8241, www.csg.org)
- The National Coalition of STD Directors (NCSDD) is a partnership of public health professionals dedicated to promoting sexual health through the prevention of STDs. NCSDD provides dynamic leadership that strengthens STD Programs by advocating for effective policies, strategies, and sufficient resources and by increasing awareness of their medical and social impact.
- The Council of State Governments is our nation's only organization serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy. This offers unparalleled regional, national and international opportunities to network, develop leaders, collaborate and create problem-solving partnerships.

1. Golden, Matthew R., et al. "Effects of Expedited Treatment of Sex Partners on Recurrence of Persistent Gonorrhea or Chlamydia Infections." *New England Journal of Medicine*. 2005; 352:7, 676-85.
2. Centers for Disease Control and Prevention. "Expedited Partner Therapy." Atlanta, GA: US Department of Health and Human Services. Access February 2, 2012 via: <http://www.cdc.gov/std/ept/>
3. Centers for Disease Control and Prevention. "2010 Sexually Transmitted Diseases Surveillance." Atlanta, GA: US Department of Health and Human Services. Access February 2, 2012 via: <http://www.cdc.gov/std/stats10/gonorrhea.htm>
4. Chesson, H.W.; Blandford, J.M.; Gift, T.L.; Tao, G.; Irwin, K.L. "The Estimated Direct Cost of STD Among American Youth, 2000." Abstract PO75. National STD Prevention Conference. Philadelphia, PA. March 8-11, 2004.
5. Rein, D.; Kassler, W.; Irwin, K., et al. "Direct Medical Cost of Pelvic Inflammatory Disease and Its Sequelae: Decreasing, But Still Substantial."
6. Centers for Disease Control and Prevention. "Gonorrhea – CDC Fact Sheet." Access on February 2, 2012 via: <http://www.cdc.gov/std/gonorrhea/STDFact-gonorrhea.htm>
7. Centers for Disease Control and Prevention. "Chlamydia – CDC Fact Sheet." Access on February 3, 2012 via: <http://www.cdc.gov/std/chlamydia/STDFact-Chlamydia.htm>
8. Wasserheit JN. 1992. Epidemiologic synergy: Interrelationships between human immunodeficiency virus infection and other sexually transmitted diseases. *Sexually Transmitted Diseases* 9:61-77.
9. Fleming, DT & Wasserheit, JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. 1999; *75*(1): 3-17.
10. Centers for Disease Control and Prevention. "HIV Prevention in the United States at a Critical Crossroads." Accessed on February 2, 2012 via: http://www.cdc.gov/hiv/resources/reports/hiv_prev_us.htm

Nothing contained in this material is intended to influence, support, or defeat any piece of pending or proposed legislation, appropriation, or regulation at any governmental level. This piece is intended for educational purposes only.

Randomized Trial: EPT reduces GC and CT re-Infection rates



Golden M, et al. *N Engl J Med* 2005 Feb 17;352(7):676-85.



Table 2: Gonorrhea, Syphilis, and Chlamydia Cases by Local Health Jurisdiction, Michigan, 2013

<i>LHJ</i>	<i>Gonorrhea</i>		<i>P&S Syphilis*</i>		<i>Chlamydia</i>		<i>Census 2010</i>
	Num	Rate [^]	Num	Rate [^]	Num	Rate [^]	
Allegan County	39	35.0	2	1.8	311	279.2	111,408
Barry-Eaton	60	35.9	2	1.2	458	274.4	166,932
Bay County	29	26.9	2	1.9	300	278.4	107,771
Benzie-Leelanau	1	2.5	0	0.0	60	152.9	39,233
Berrien County	185	118.0	3	1.9	782	498.7	156,813
Branch-Hillsdale-St. Jc	21	13.7	2	1.3	312	203.6	153,231
Calhoun County	225	165.3	4	2.9	758	556.8	136,146
Central Michigan Distr	37	19.4	3	1.6	456	239.0	190,805
Chippewa County	4	10.4	0	0.0	131	340.1	38,520
Delta-Menominee	4	6.5	0	0.0	98	160.4	61,098
Dickinson-Iron	4	10.5	0	0.0	55	144.8	37,985
District 2	2	3.0	0	0.0	79	117.6	67,168
District 4	8	10.1	0	0.0	124	157.2	78,891
District 10	19	7.3	0	0.0	532	203.4	261,616
Genesee County	921	216.3	13	3.1	2,516	590.9	425,790
Grand Traverse Count	9	10.3	2	2.3	248	285.1	86,986
Huron County	1	3.0	0	0.0	48	144.9	33,118
Ingham County	435	154.9	12	4.3	1,823	649.0	280,895
Ionia County	13	20.3	0	0.0	126	197.2	63,905
Jackson County	56	34.9	3	1.9	642	400.6	160,248
Kalamazoo County	286	114.2	6	2.4	1,592	636.0	250,331
Kent County	648	107.5	11	1.8	3,734	619.6	602,622
Lapeer County	9	10.2	1	1.1	154	174.4	88,319
Lenawee County	21	21.0	1	1.0	208	208.2	99,892
Livingston County	22	12.2	2	1.1	263	145.3	180,967
Luce-Mack-Alger-Schc	6	21.9	0	0.0	52	190.2	27,345
Macomb County	590	70.2	33	3.9	2,583	307.1	840,978
Marquette County	8	11.9	0	0.0	221	329.5	67,077
Midland County	31	37.1	1	1.2	164	196.1	83,629
Mid-Michigan District	10	5.5	1	0.6	437	241.2	181,200
Monroe County	79	52.0	2	1.3	358	235.5	152,021
Muskegon County	205	119.1	1	0.6	1,191	691.7	172,188
Northwest MI Com Hlti	16	15.0	0	0.0	181	170.1	106,387
Oakland County	877	72.9	69	5.7	3,526	293.3	1,202,362
Ottawa County	94	35.6	0	0.0	728	276.0	263,801
Saginaw County	267	133.4	4	2.0	1,149	574.0	200,169
Sanilac County	-	0.0	0	0.0	63	146.1	43,114
Shiawassee County	7	9.9	1	1.4	147	208.1	70,648
St Clair County	55	33.7	2	1.2	437	268.0	163,040
Tuscola County	15	26.9	0	0.0	118	211.7	55,729
Van Buren-Cass	46	35.8	0	0.0	335	260.6	128,551
Washtenaw County	231	67.0	22	6.4	1,379	400.0	344,791
Wayne County	1,023	92.4	74	6.7	4,222	381.5	1,106,807
Detroit City	4,072	570.5	217	30.4	11,609	1626.4	713,777
Western UP District	5	7.1	0	0.0	86	121.4	70,851
Total	10,698	108.2	496	5.0	44,796	453.2	9,883,640

* P&S: Primary and Secondary Syphilis

[^] Rate per 100,000

Table 1: Gonorrhea, Syphilis, and Chlamydia Cases by Sex, Race and Age Group, Michigan, 2013

RACE/ ETHNICITY	Gonorrhea			P&S Syphilis*			Chlamydia			Census 2010
	Num	%	Rate [^]	Num	%	Rate [^]	Num	%	Rate [^]	
White non-Hispanic	1,467	14%	19.4	133	27%	1.8	11,445	26%	151.2	7,569,939
Black non-Hispanic	5,647	53%	408.1	336	68%	24.3	16,643	37%	1202.7	1,383,756
Hispanic	175	2%	40.1	17	3%	3.9	1,156	3%	264.9	436,358
Other/Multi	169	2%	34.2	6	1%	1.2	906	2%	183.6	493,587
Unknown Race	3,240	30%	N/A	3	1%	N/A	14,646	33%	N/A	
SEX & RACE										
Males	4,755	44%	98.1	465	94%	9.6	12,682	28%	261.6	4,848,114
White Males	635	6%	17.0	128	26%	3.4	2,803	6%	75.2	3,728,507
Black Males	2,593	24%	394.6	312	63%	47.5	5,375	12%	817.9	657,181
Hispanic Males	68	1%	30.6	16	3%	7.2	355	1%	160.0	221,913
Other Males	66	1%	27.4	6	1%	2.5	262	1%	108.9	240,513
Unknown Males	1,393	13%	N/A	3	1%	N/A	3,887	9%	N/A	
Females	5,931	55%	117.8	30	6%	0.6	32,017	71%	635.8	5,035,526
White Females	831	8%	21.6	5	1%	0.1	8,626	19%	224.6	3,841,432
Black Females	3,052	29%	420.1	24	5%	3.3	11,256	25%	1549.2	726,575
Hispanic Fem.	107	1%	49.9	1	0%	0.5	801	2%	373.5	214,445
Other Females	103	1%	40.7	0	0%	0.0	642	1%	253.7	253,074
Unknown Fem.	1,838	17%	N/A	0	0%	N/A	10,692	24%	N/A	
Unknown Sex - All Races	0	0%	N/A	0	0%	N/A	97	0%	N/A	
Age										
0-4 years	8	0%	1.3	0	0%	0.0	37	0%	6.2	596,286
5-9 years	2	0%	0.3	0	0%	0.0	3	0%	0.5	637,784
10-14 years	96	1%	14.2	0	0%	0.0	537	1%	79.5	675,216
15-19 years	2,759	26%	373.0	39	8%	5.3	14,772	33%	1997.3	739,599
20-24 years	3,980	37%	594.9	154	31%	23.0	18,319	41%	2738.0	669,072
25-29 years	1,763	16%	299.0	99	20%	16.8	6,200	14%	1051.6	589,583
30-34 years	829	8%	144.3	65	13%	11.3	2,441	5%	424.8	574,566
35-39 years	485	5%	79.2	47	9%	7.7	1,157	3%	188.9	612,493
40-44 years	308	3%	46.3	31	6%	4.7	594	1%	89.3	665,481
45-54 years	307	3%	20.3	46	9%	3.0	461	1%	30.5	1,510,033
55-64 years	96	1%	7.7	10	2%	0.8	110	0%	8.8	1,251,997
65 and over	48	0%	3.5	4	1%	0.3	108	0%	7.9	1,361,530
Unknown Age	17	0%	N/A	0	0%	N/A	57	0%	N/A	
Total	10,698	100%	108.2	495	100%	5.0	44,796	100%	453.2	9,883,640

* P&S: Primary and Secondary Syphilis

[^] Rate per 100,000

STD Briefing Document

Michigan Senate District 12

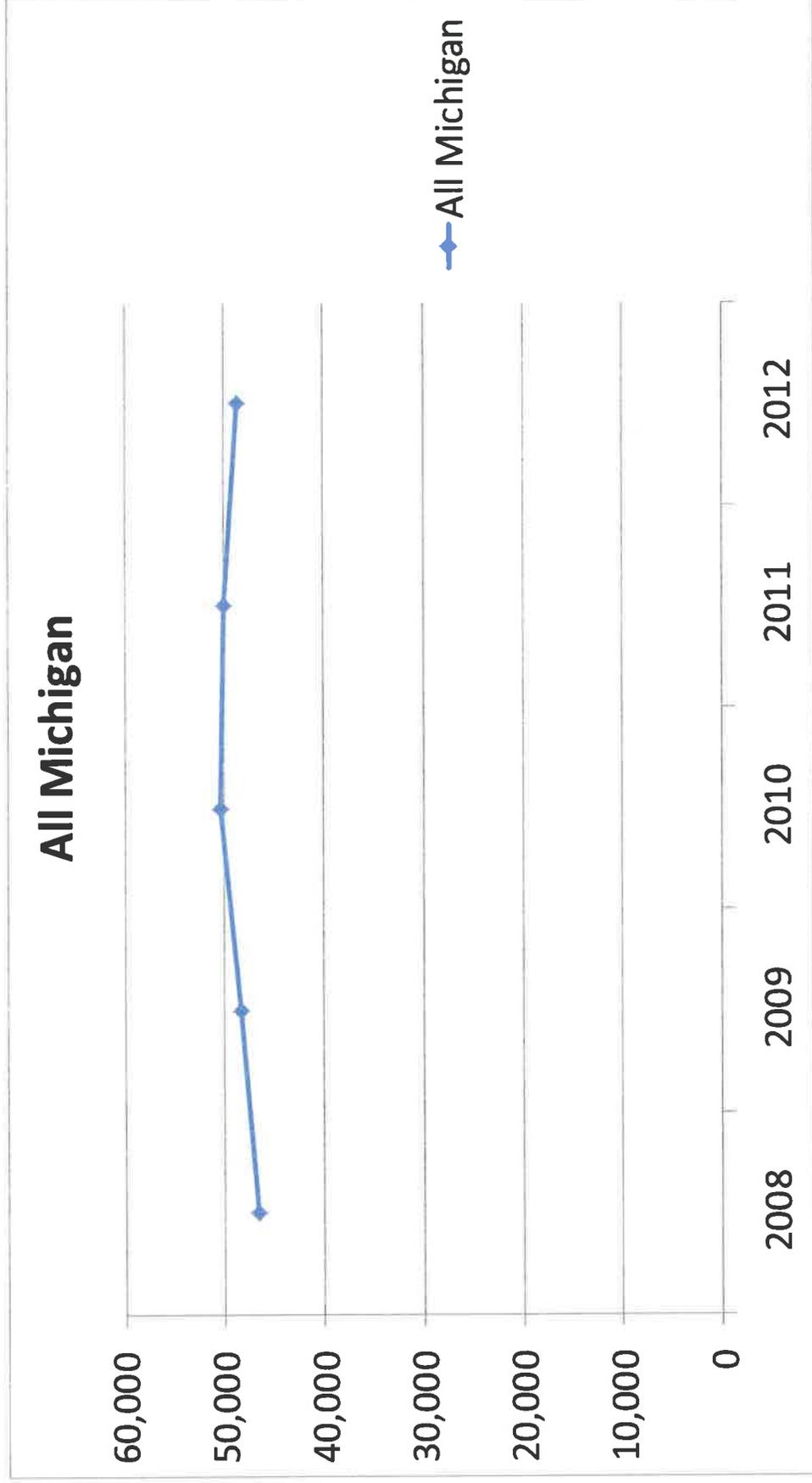
based on 2001 Census Apportionment



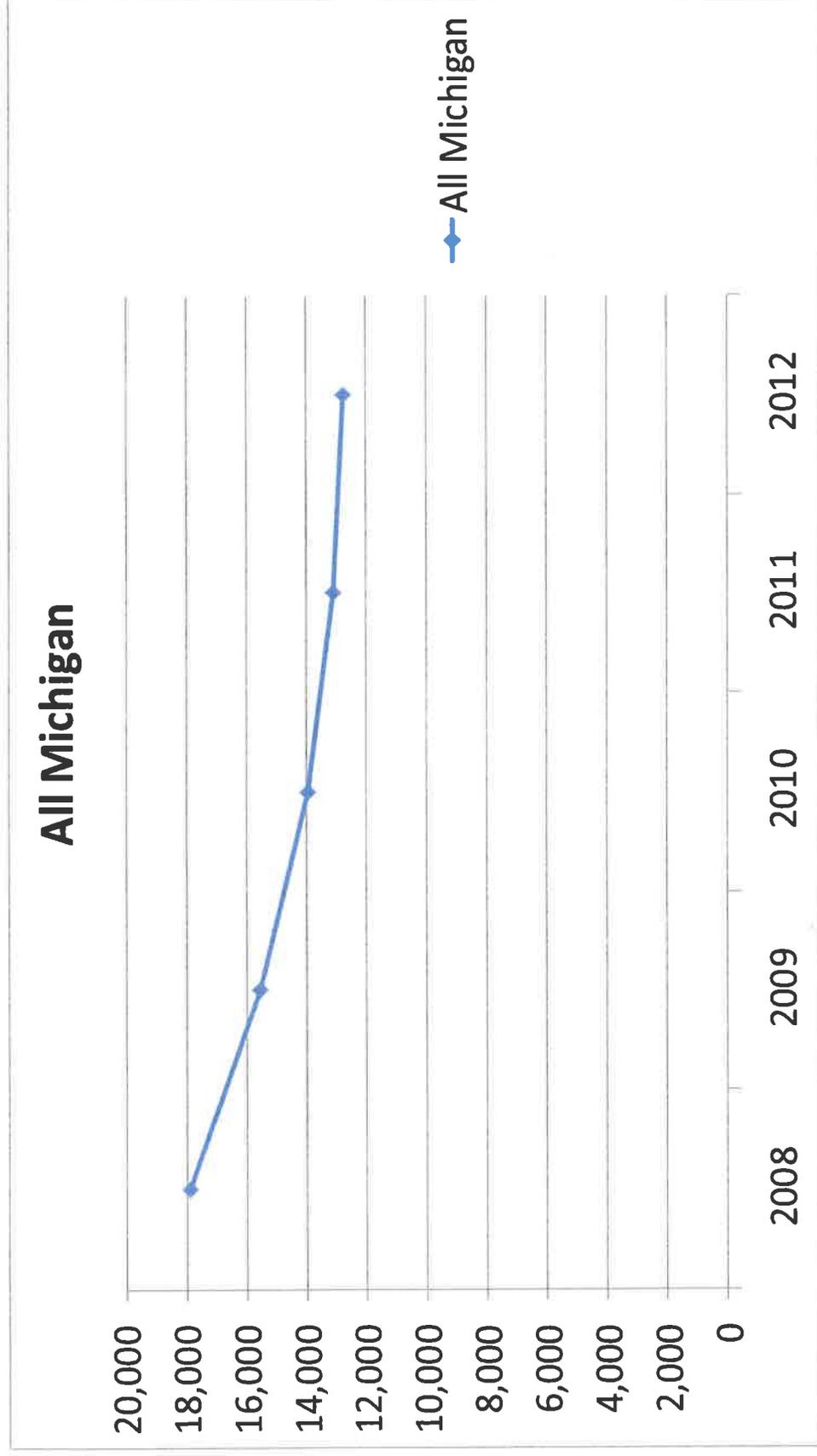
Prepared by Jim Kent

December 2013

MI Chlamydia Cases by Year



MI Gonorrhoea Cases by Year



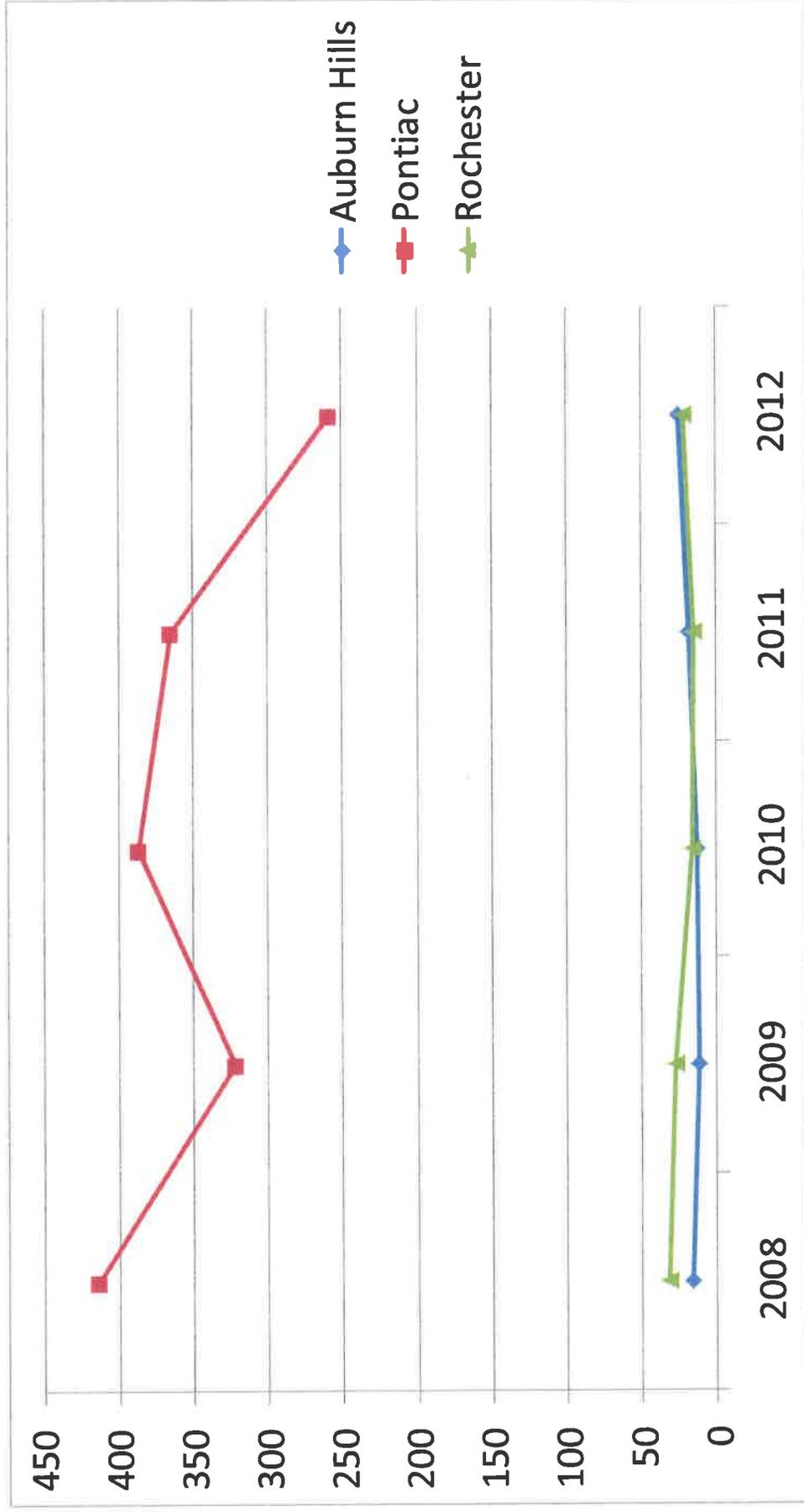
Chlamydia Cases by Year

Senate District 12



Gonorrhea Cases by Year

Senate District 12



STD Comparison by Geography

Statewide versus Senate District 12

- The statewide rate of chlamydia in 2012 was 4.9 per 1,000 population
 - Auburn Hills: 4.5
 - Pontiac: 14.4
 - Rochester: 6.7
 - Rochester Hills: 0.2
- The statewide rate of gonorrhea in 2012 was 1.3 per 1,000 population
 - Auburn Hills: 1.2
 - Pontiac: 4.4
 - Rochester: 1.6
 - Rochester Hills: 0

2012 STD Rankings

Among 83 Michigan Counties

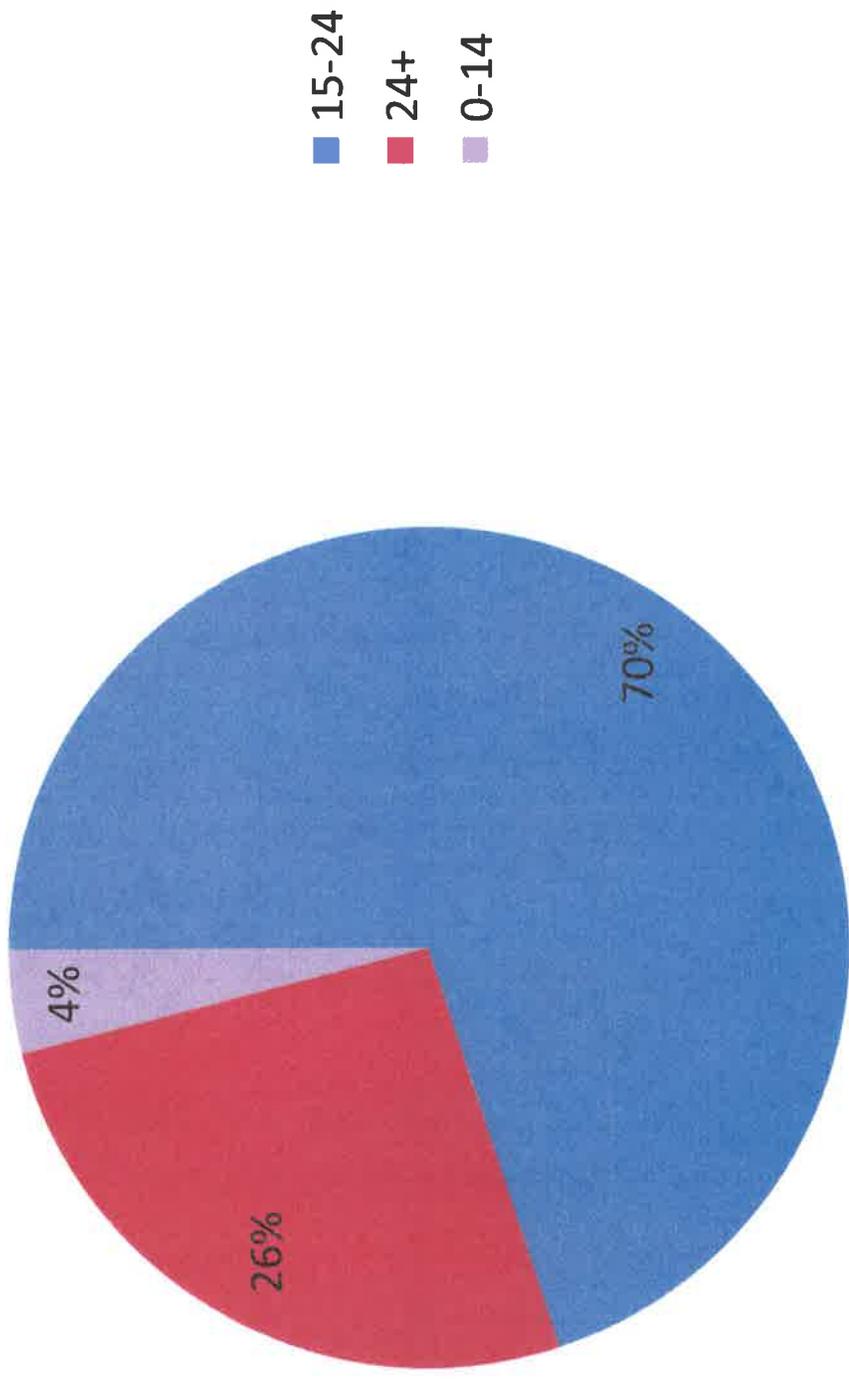
Rate of chlamydia cases per population:

- Oakland County ranks 20th

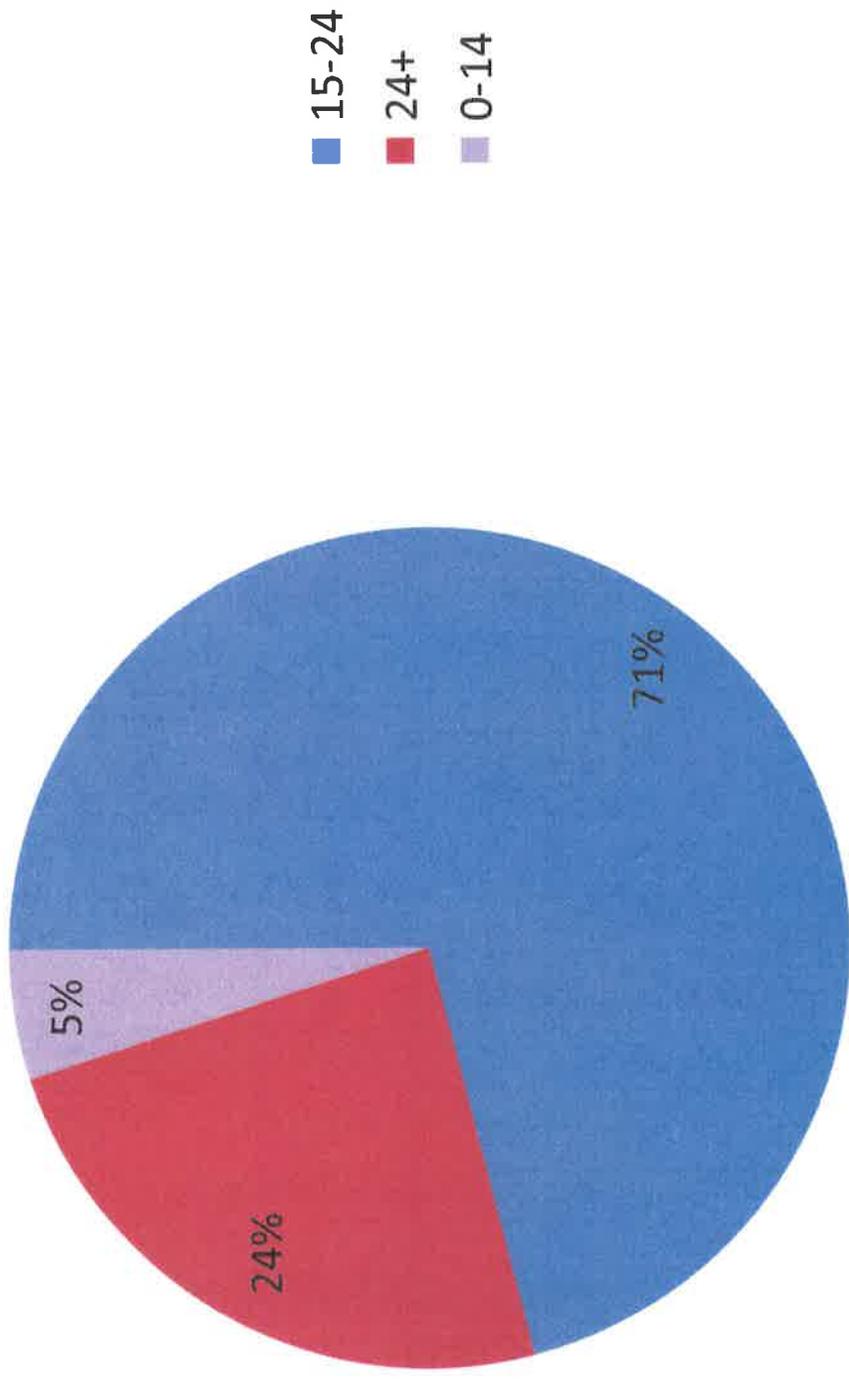
Rate of gonorrhea cases per population:

- Oakland County ranks 11th

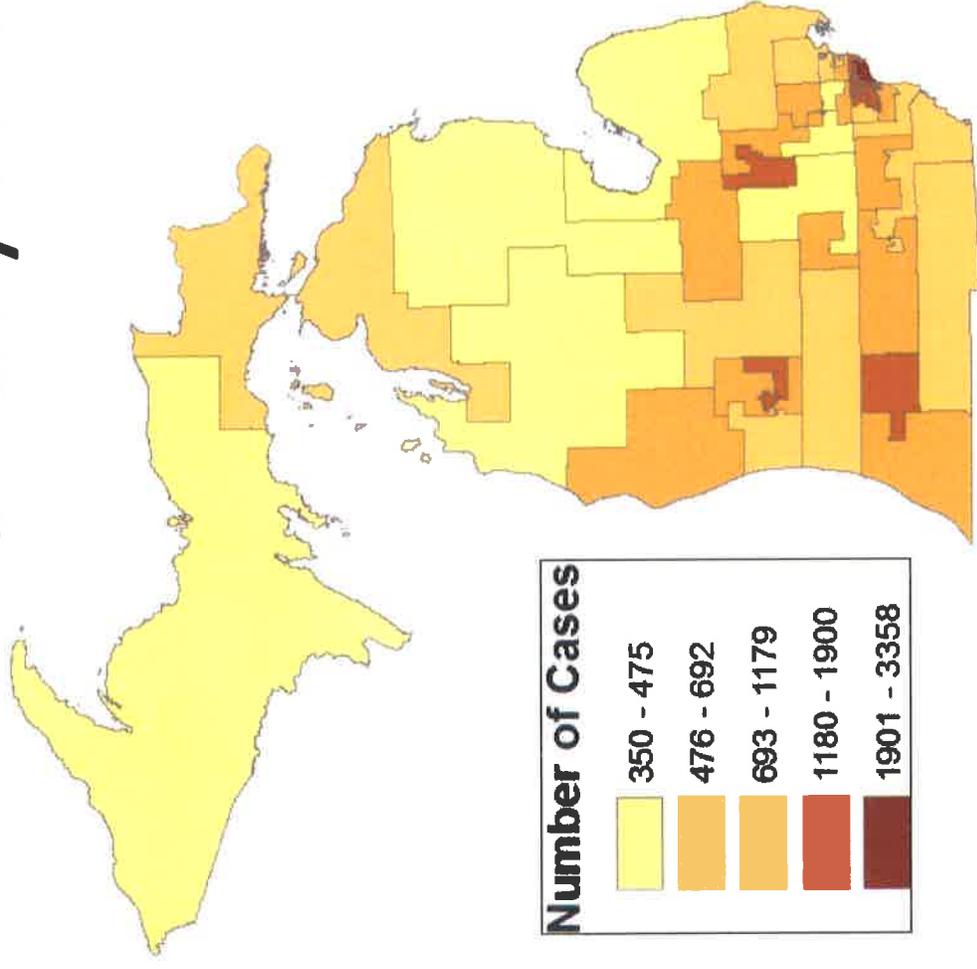
Percent of STD Cases Among Teens and Young Adults Statewide Michigan, 2008- 2012



Percent of STD Cases Among Teens and Young Adults Senate District 12, 2008- 2012



Michigan 2012 Chlamydia Cases



Michigan 2012 Chlamydia Cases Senate District 12

