

EVALUATION OF A PUBLIC HEALTH NURSING EXPEDITED  
PARTNER THERAPY PROGRAM

By

Colleen McNulty

RECOMMENDED:

---

Sheli Delaney, MA

---

Elizabeth Hodges Snyder, PhD, MPH

---

Nancy Nix, MD, MPH&TM, MEd, CHES  
Chair, Advisory Committee

---

Virginia Miller, DrPH, MS, MPH  
Chair, Department of Health Sciences

APPROVED:

---

Susan Kaplan, PhD  
Administrative Dean, College of Health

---

Date

EVALUATION OF A PUBLIC HEALTH NURSING EXPEDITED

PARTNER THERAPY PROGRAM

A

PROJECT REPORT

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By

Colleen McNulty, BSN

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## **Abstract**

Expedited Partner Therapy (EPT) is an important strategy in reducing reinfection for clients with a positive chlamydia or gonorrhea lab test. It also reduces the time it takes to treat partners, therefore decreasing the rapid spread of these diseases. In 2012, the Alaska Section of Public Health Nursing began to establish an EPT process. The purpose of this program evaluation was to determine uptake in EPT clinical services and to identify barriers both in the process and in staff knowledge and support of EPT practice. Several methods of data collection were used including historical data review, focus group discussion and online survey. Based on the data review, EPT was offered to only 13.7% of clients with a positive chlamydia and/or gonorrhea tests, although of the clients who used EPT, 94.7% reported that using EPT was a positive option for them. Both the focus group discussion and online survey demonstrated that the process set up for provision of EPT by public health nurses was lengthy and difficult for staff to follow. There were also barriers with nurses using EPT due to fear of a potential allergic reaction (35.4%) and fear it could increase antimicrobial resistance (12.5%). The recommendations made were to: reduce the number of required steps of the process for providing EPT to clients; provide ongoing education on evidence-based reporting of EPT services; and to provide support for the public health nurse staff.

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## Chapter 1: Introduction and Background

In 2012, the Alaska Section of Public Health Nursing (SOPHN) formed a team to begin exploring the use of Expedited Partner Therapy (EPT). An internal policy was developed and approved, as well as a medical directive to allow Public Health Nurses (PHNs) to deliver EPT to clients. An online educational training was developed and provided to staff using webinar technology. Additionally, the training was recorded and archived for those who were unable to attend the live webinar. The first dose of EPT was given by a State of Alaska PHN in October of 2013.

Since its inception in the SOPHN, the use of EPT to treat partners has been low, despite the SOPHN's continued support of EPT both financially and in policy. The reasons for the under-utilization of EPT service are not clear. Evaluation of the program is necessary to begin a quality improvement process and potentially increase the use of EPT.

*Chlamydia trachomatis* (CT) infection is the most common reportable disease in the United States. (Centers for Disease Control and Prevention [CDC], 2014). Approximately 75% of untreated chlamydia infections contribute to pelvic inflammatory disease, preterm labor, ectopic pregnancy, and/or subsequent infertility in women. Infected men are at risk for epididymitis and Reiter's syndrome. Infants born to chlamydia positive mothers can suffer from conjunctivitis and chlamydial pneumonia (Cecere & Jones, 2014a). *Neisseria gonorrhoeae* (GC) infection can cause serious complications when not treated, but can be cured with the right medication. The GC rates, although very low relative to the 1970s and 1980s, are relatively steady and in some states are on the increase. Untreated gonorrhea is a major cause of pelvic inflammatory disease and ectopic pregnancy in women, and can lead to infertility. Among males with gonococcal infection, epididymitis and infertility may occur. Infants born to GC positive

mothers are at risk for conjunctivitis requiring treatment with antibiotics (Cecere & Jones, 2014b).

Effective clinical management of clients with chlamydia and/or gonorrhea requires treatment of their current and recent sex partners to reduce reinfection rates, and to stop rapid transmission of the sexually transmitted diseases (STDs). Typically, an interview with the infected individual is conducted and names of recent sexual partners are elicited. The provider can then outreach to the contacts directly to advise them in a confidential manner that they have been named as a sexual contact to someone with an STD. Counseling on treatment and further testing options is given at this time. Although this provider-assisted method is considered the optimal strategy for partner notification, it requires a considerable amount of time to outreach to all contacts by the provider. Additionally, clients may be reluctant to disclose the names of his/her partner(s). They may also state their partner(s) will not come in for treatment or testing due to stigma of being seen at a public health center, or they have a lack of transportation, or a lack of concern about being infected.

One option that has been shown to be effective in partner notification and treatment is the use of EPT (CDC, 2006). This method allows the provider to give either a prescription or medications to the infected individual to give to his/her partner(s) without requiring the partner(s) to be seen at the clinic. Contacts should also receive information on the safe use of the medication, resources for further testing, and education on prevention of STDs in the future. A study done by Golden et al. (2007) with the King County Health Department found that the estimated percentage of person with GC or CT infection for whom all partners were treated rose from 39% to 65% concurrent with the institution of their EPT program. Expedited partner therapy represents a strategy to facilitate partner management in addition to provider-assisted

referral. According to Hogben, Kidd & Burstein (2012), EPT has been in existence informally for decades. In a large retrospective analysis in New York City, 54.8% of clients, overall, accepted EPT when offered, demonstrating a high level of acceptance by the public (Vaidya, Johnson, Rogers, Nash & Schillinger, 2014). However, in one study done at five pediatric clinics in Oak Lawn, Illinois, only 25% of physicians utilized EPT in their practice, demonstrating a low rate of acceptance in providers seeing high risk teens (Mears, Kelly, Kaviany, Reggi & Amidon, 2014).

In May, 2005, Dr. John M. Douglas, Jr., Director of the Division of STD Prevention at the CDC, sent all licensed U.S. medical providers a “Dear Colleague Letter” supporting and encouraging EPT as a useful option to facilitate partner management for both chlamydia and gonorrhea infections. Dr. Douglas, Jr. further directed the preparation of a report published and distributed as support and guidelines for the use of EPT (CDC, 2006). Over the next several years, professional organizations began to issue supportive statements and position papers. These organizations included the American Medical Association, Society for Adolescent Medicine, American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Alaska has consistently had the first or second highest chlamydia rate in the United States since 2000 (Cecere & Jones, 2014a). In 2008, an increase in gonorrhea infection was discovered in the Southwest region, and it continued to increase over the next two years, ranking Alaska with the third highest gonorrhea rate in the nation (Cecere & Jones, 2014b). In 2010, the State of Alaska’s Section of Epidemiology (SOE) worked with health clinicians at the local, state and federal level to determine response activities that could combat the increasing rates of both chlamydia and gonorrhea, including the use of EPT (Cecere, Senft & Jones, 2011).

Although state law did not prohibit EPT in Alaska, in September 2010, the State Medical Board modified regulation 12AAC40.967 to formally sanction its use in Alaska by Physicians and Physician Assistants. Specifically, the new regulation states that “Unprofessional conduct includes the following: ... (20) prescribing, dispensing, or furnishing a prescription medication to a person without first conducting a physical examination of that person, unless the licensee has a patient-physician or patient-physician assistant relationship with the person; this paragraph does not apply to prescriptions written or medications issued (A) for use in emergency treatment; (B) for expedited partner therapy for sexually transmitted diseases.” [Alaska Administrative Code title 12, § 40.967(29)(B)]. By January 2012, the Alaska Board of Nursing made a policy statement to allow for EPT by Advanced Nurse Practitioners. These legal moves paved the way for Alaskan health providers to offer EPT services to local residents.

A full assessment of knowledge and attitude surrounding EPT use in Alaska was conducted by the CDC and Alaska Section of Epidemiology beginning in May 2010, (Cecere & Jones, 2010) and the findings were subsequently published in January 2011. Knowledge, attitudes and practices of EPT among policy makers, health care providers and clients were determined in this report. Surveys and interview findings indicated that EPT was considered an acceptable partner management tool. In fact, 88% of respondents agreed that EPT would decrease the spread of STDs in Alaska (Cecere, Senft & Jones, 2011). Sixty percent thought that EPT should be considered the standard of care, while 28% agreed with the statement that EPT was too dangerous without knowing the partners’ allergy/medical histories. The next step was the development of a plan for promoting the implementation and evaluation of EPT services as a tool to reduce the STD epidemic in Alaska and to mitigate the burden of morbidity from

untreated chlamydia and gonorrhea. Furthermore, several important recommendations for EPT implementation were identified and addressed (Cecere, Senft & Jones, 2011):

1. Health care providers should consider using EPT to treat contacts to CT and/or GC.
2. Health care providers should formulate policies and procedures for use of EPT.
3. Symptomatic partners receiving EPT should be encouraged to seek medical attention.
4. Health care providers should ensure that EPT medications are available for their use.
5. Providers must still report confirmed infections to the Alaska Section of Epidemiology.

In March 2012, based on these recommendations, SOPHN formed a team to investigate the potential use of EPT by public health nurses and advanced nurse practitioners. Included in this team were two regional nurse managers, one health practitioner, one nurse manager, two advanced public health nurses (PHN IIIs) and one nurse consultant. A Gantt chart was created to communicate the project timeline and to monitor progress of the workgroup.

The team reviewed and followed the guidance in the CDC publication “Expedited Partner Therapy in the Management of Sexually Transmitted Diseases”, which served as a reference document for guidelines and program implementation. The team also identified other organizations and states that had successfully implemented EPT, including an Alaskan tribal organization that had successfully implemented an EPT program in their outpatient clinic.

Interviews were conducted with the tribal organization staff and resources were shared including patient handouts, policies and medical directives.

The team reviewed the information, presented the findings and proposed a plan to offer EPT for public health clients to SOPHN nursing senior leadership. Following consultation with the Section of Epidemiology, a decision was made to implement an EPT program in Public Health Nursing. Several documents were required prior to pilot testing, including medical directives, policies and procedures, charting guidelines and patient handouts. A comprehensive plan to provide education for all public health nurses was developed. This included a recorded webinar and learning modules in Moodle for tracking public health nurse participation.

The SOPHN process required for providing EPT to clients included the following steps:

1. The clients must have a documented positive lab test for CT and/or GC.
2. Standardized charting was developed and must be followed exactly to allow the nurse informatics team to demonstrate accurate rates of utilization of EPT.
3. The number of doses is provided for all sexual contacts in the past 60 days, and written education sheets are given to the client for each partner.
4. All clients are contacted by phone 10 days later to assure the medications were given to their sexual contacts.
5. During this 10 day phone call, two questions are asked for assessing client satisfaction.
6. Another STD test for reinfection is done after 90 days.
7. If a client does not show up for the 90 day test of reinfection, or there is not an appointment scheduled, the nurse will outreach to the client by phone.

A client seen with a positive CT and/or GC lab test is assessed by the PHN for eligibility for EPT, and two groups of clientele are not considered eligible. Clients who disclose intimate partner violence may be at increased risk for escalating violence by providing EPT to their partner. Also, men who have sex with men are at an increased risk of other STDs such as Hepatitis C and HIV or AIDS, and therefore are recommended to come to the clinic for a full STD screening.

Initially, four health centers were identified as pilot sites for EPT services during the first quarter of the 2013 fiscal year (FY 2013). All public health nurses at these locations participated in the training and educational activities, and were given the opportunity to provide feedback to the EPT team via a survey. Pretests and posttests were completed in Moodle (online training system), which clearly demonstrated increased knowledge regarding the EPT program components. The pretest mean score was 61.62% with a standard deviation of 17.52 and the posttest mean score was 93.12% with a standard deviation of 6.55.

The first dose of EPT was distributed at one of the pilot sites in October 2013. Also during this time, all PHNs statewide were required to participate in the training and EPT was provided statewide by January 2014. The EPT program has now been operating for over two years. The senior leadership for SOPHN was interested in an evaluation of this program. Some concerns have been that the use of EPT is minimal and perhaps limited due to resistance by health center or even by individual PHNs. Changing health care practices can be difficult and may be hindered by a provider's attitudes, ideas and practices. Practice uncertainty occurs when health care providers are uncomfortable as a result of unfamiliar or challenging patient care situations (Grol & Grimshaw, 2013). This program evaluation was to determine if practice uncertainty has occurred and what areas of change require further education and support.

## **Chapter 2: Project Goals and Objectives**

The goal of this project was to evaluate the process and outcome of the State of Alaska SOPHN EPT Program in order to improve their service delivery to control and prevent chlamydia and gonorrhea in Alaska. It was critical that data be collected to determine the feasibility of continuing to offer EPT to public health center clients. A full process evaluation was needed to provide important information for the SOPHN to be able to develop an improvement plan for this program.

The project objectives were to:

1. Assess program fidelity and the implementation process.
2. Review records and collect data on the use of EPT by State PHNs and compliance with client follow-up and testing protocols between October 1, 2012 through January 31, 2015 to quantify the number of EPT services.
3. Conduct a focus group discussion (FGD) of the original members of the EPT team to elicit potential barriers in using EPT to incorporate in the PHN survey.
4. Conduct an online survey of PHN staff to identify barriers with the EPT Program, and PHN knowledge, satisfaction, attitudes and beliefs about the use of EPT.

### **Chapter 3: Methods**

This program evaluation included a mixed method approach, both qualitative and quantitative, for data collection. Quantitative data were extracted from the SOPHN Resource and Patient Management System (RPMS) database. As discussed earlier, these data were dependent on the nurse documentation of EPT services using standardized charting, which was provided during staff education. The data requested from the nursing informatics team included number of clients receiving EPT, whether standardized charting was used for each step, number of 10 day phone calls, results of the satisfaction questions, number of 90 day phone calls and number of 90 day tests of reinfection. Qualitative data were collected using an FGD and an online survey.

#### **Diffusion of Innovation Theory**

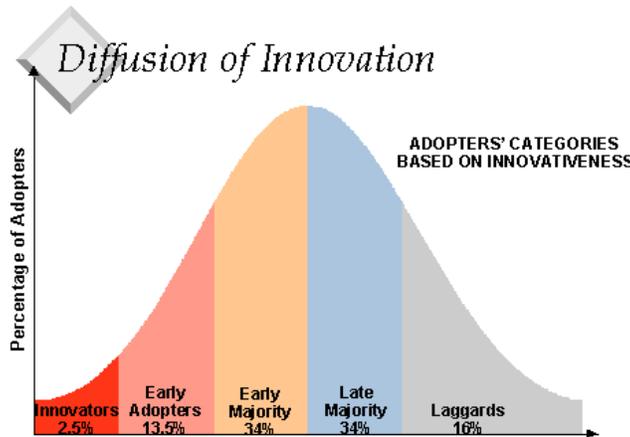
The Diffusion of Innovation (DOI) Theory was developed by E.M. Rogers in 1962. This is one of the oldest social science theories. It explains how, over time, an idea gains momentum and spreads through a population or system. The end result is that people adopt a new idea, product or behavior. The key to adoption is that the individual must perceive the idea, product or behavior as new or innovative, making diffusion possible. The introduction of EPT in public health centers was not only a new idea, but it required the PHNs to modify their behavior in the clinic when providing STD services.

Adoption of an innovation doesn't happen simultaneously in a system, rather it is a process whereby some people are more apt to adopt the changes than others. There are five categories of adopters, and when promoting an innovation, there are different strategies used to appeal to the different adopter categories.

1. Innovators – These are people who are first in line to adopt the changes. They are excited about new ideas and are often willing to take risks in developing new ideas. Little action needs to be done to appeal to this category. The PHN innovators would readily adopt the new EPT process and begin to offer this service to clientele when the program began.
2. Early Adopters – These individuals are opinion leaders, they embrace change opportunities. They are aware of the need to change and are comfortable with adopting new ideas. Strategies to entice this group include how-to manuals and information on implementation for the new changes. Following the education that SOPHN provided to all PHN staff, the early adopters would begin implementing the EPT process into their practice.
3. Early Majority – These people are rarely leaders, but they will adopt new ideas before the average person. They typically will need to see evidence that the innovation works before they are willing to adopt it. Strategies that support this category include sharing success stories and evidence of the effectiveness of the innovation. Once the EPT program was beta tested in the four communities, the early majority adopters would benefit from hearing how these PHNs implemented EPT successfully and how positive their clients responded in the satisfaction survey.
4. Late Majority – These individuals can be skeptical of change, and typically will only adopt an innovation after it has been tried by the greater majority. Strategies to appeal to this population include information on how many others have tried the changes and have been successful. As the EPT program continued, the late majority PHNs could be inspired to implement the process into their practice with updates from successful users

over time. Quarterly statistics on uptake and client satisfaction would be beneficial to this group.

5. Laggards – These people are bound by tradition and are very conservative. They remain skeptical of change and are the most difficult group to adopt changes. Strategies for this population include statistics and peer pressure from other adopter groups. Identification of successful PHNs using EPT in their practice may be helpful in convincing this reluctant group to try the process, perhaps by closely mentoring the nurse when seeing a client in the clinic (Figure 1).



**Figure 1: Diffusion of Innovation Theory Categories of Adopters**

The stages in which a person adopts an innovation are also defined in the DOI Theory. These include awareness of the need for change, decision to adopt (or reject) the innovation, initial use or testing of the innovation, and continued use of the innovation. There are also five factors that influence the adoption of the innovation, each which affect the individual to a different extent in the five adopter categories.

1. Relative Advantage – The degree to which the innovation is seen as better than the idea, product or program it is replacing. For EPT, a close comparison of traditional

confidential contact investigation and the process of providing EPT medications would be helpful in defining the advantages in using this new strategy.

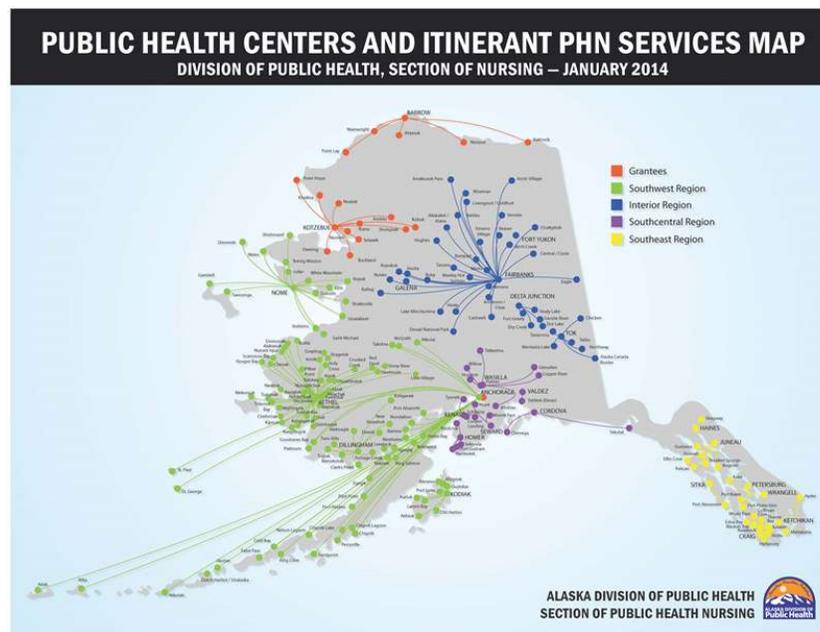
2. Compatibility – How consistent the innovation is with the experiences and needs of the adopters. Adult learning theories support the need to assess where the new user is with their past experiences and their knowledge base prior to offering education. There may be staff that has used EPT in previous jobs, and they may have different needs compared to new PHNs.
3. Complexity – How difficult the innovation is to understand and to use. As discussed earlier, the process for providing EPT has several steps and requires staff to track the client over three months, so it can be complicated.
4. Trialability – The extent in which the innovation is tested and trialed before a commitment to adopt the changes can be made. The EPT program was beta tested in four communities, but only for two to three months before it was to be implemented statewide.
5. Observability – The extent in which the innovation provides positive and measurable results. This evaluation is the first one done for the EPT program, so it is difficult to measure results to share with staff.

The DOI Theory aptly describes the process in changing how public health nurses can embrace the changes from doing traditional confidential contact investigations, to providing EPT to clients with positive sexually transmitted diseases. It also gives the SOPHN information on some strategies that can be used to influence different groups of adopters to make changes and adopt this new innovation. Although this theory did not originate in public health, it has been used successfully in many fields. The most successful adoption of a public health program

results from understanding the target population and the factors which influence their rates of adoption.

## Study Population and Sample

In the state of Alaska there are four regions, which include 21 health centers and 121 PHNs. These PHNs provide services in the health centers as well as itinerating to 256 villages in Alaska. For this evaluation the target population was the SOPHN (Figure 1).



**Figure 2: Alaska Section of Public Health Nursing Regions**

## Protection of Human Subjects

Before beginning this evaluation, the researcher completed ethical research training and earned Collaborative Institutional Training Initiative (CITI) certification (Appendix A) and the University of Alaska Anchorage Institutional Review Board (IRB) reviewed and approved this project. De-identified data were provided by the nurse informatics team to the investigator. For

the FGD, informed consent was obtained electronically using a poll before the FGD (Appendix B). The online survey was conducted using Survey Monkey and the settings were for anonymous data collection. Informed consent was obtained in the first question, and those who declined were exited from the survey (Appendix C).

### **Data Review**

The RPMS database is a robust healthcare system used by Indian Health Services nationwide. Public Health Nursing has been using this system since the mid 1980's. The SOPHN nursing informatics team gathered and provided data with no patient identifiers to the principal investigator. These data, between October 1, 2012 and January 31, 2015, included the following:

- Number of clients receiving EPT.
- Number of doses of EPT given to all clients statewide.
- Number of doses of EPT given/not given to partners.
- Number of follow up phone calls to clients 10 days after EPT provided.
- Number and results of retests completed at 90 days after EPT provided (reinfection rate).

### **Focus Group Discussion**

The FGD consisted of seven of the eight original members of the EPT team for SOPHN. Informed consent was collected electronically by including the consent as a poll using GoToWebinar technology (Appendix B). This team was critical in initiating the EPT program in

Alaska and each member is a subject matter expert. It was important to identify potential barriers for the PHN staff in providing EPT to include in the follow up survey of PHN staff. A FGD question guide of topic areas was developed and used to prompt further, more in depth discussions (Appendix D). GoToWebinar technology was used to hold the FGD since the EPT team resided and worked in locations throughout the state. The FGD was recorded digitally and transcribed by the researcher later. The FGD facilitator began with a brief introduction of the proposed program evaluation, and as themes developed around potential barriers, the facilitator clarified and restated the issue for group consensus. Once the recording was transcribed, thematic analysis was applied and common themes were identified.

### **Survey of Public Health Nurses**

An online survey was developed to determine strengths, weaknesses and barriers of providing EPT to SOPHN clients (Appendix E). The evaluation questions assessed staff education and comfort level when talking with clients, belief in the safety of EPT, confusion in the process, and barriers to documentation. The majority of the questions were multiple choice. Select questions were open-ended and comment boxes were provided as well. The tool was pre-tested with a small number of the SOPHN nurses representing all four of the SOPHN regions. Once vetted, the survey was sent to all PHNs statewide. This survey was set for anonymous data collection to protect confidentiality of the nurses participating. Informed consent was obtained electronically, and those who declined were exited from the survey (Appendix C). At this time, 123 public health nurses and advanced nurse practitioners were employed by the SOPHN. By policy, PHNs are expected to introduce EPT to their clients and offering EPT for partner treatment.

## **Data Analysis of SOPHN EPT Services**

The RPMS data on EPT services provided by SOPHN between October 1, 2012 and January 31, 2015 were provided from the SOPHN nurse informatics team in a list format. Each of the required steps per policy was measured to determine if it was done and if it was documented using standardized charting.

The FGD was digitally recorded and transcribed at a later date by the researcher. Thematic analysis was performed to identify themes; underutilization of EPT, process deviation and EPT process management.

The online survey data were collected and analyzed in Survey Monkey. The survey remained open for three weeks, and a reminder email was sent to all staff one week prior to closing. The data was then exported into an Excel spreadsheet for further analysis.

## Chapter 4: Results

### Data Review of SOPHN EPT Services between October 1, 2012 and January 31, 2015

Of the 123 public health nurses and advanced nurse practitioners, 55 responded, for a 45% response rate. During the time period of October 1, 2012 through January 31, 2015, there were 15,752 PHN visits for STD services throughout the state of Alaska. Of these, there were 1,315 positive cases of *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (GC) infections. The overall positivity rate for testing was 8.34%. Of the positive cases, 88.97% were CT and 11.03% were GC (Table 1).

**Table 1: Positive CT and/or GC for Alaska Section of Public Health Nursing From October 1, 2012 through January 31, 2015**

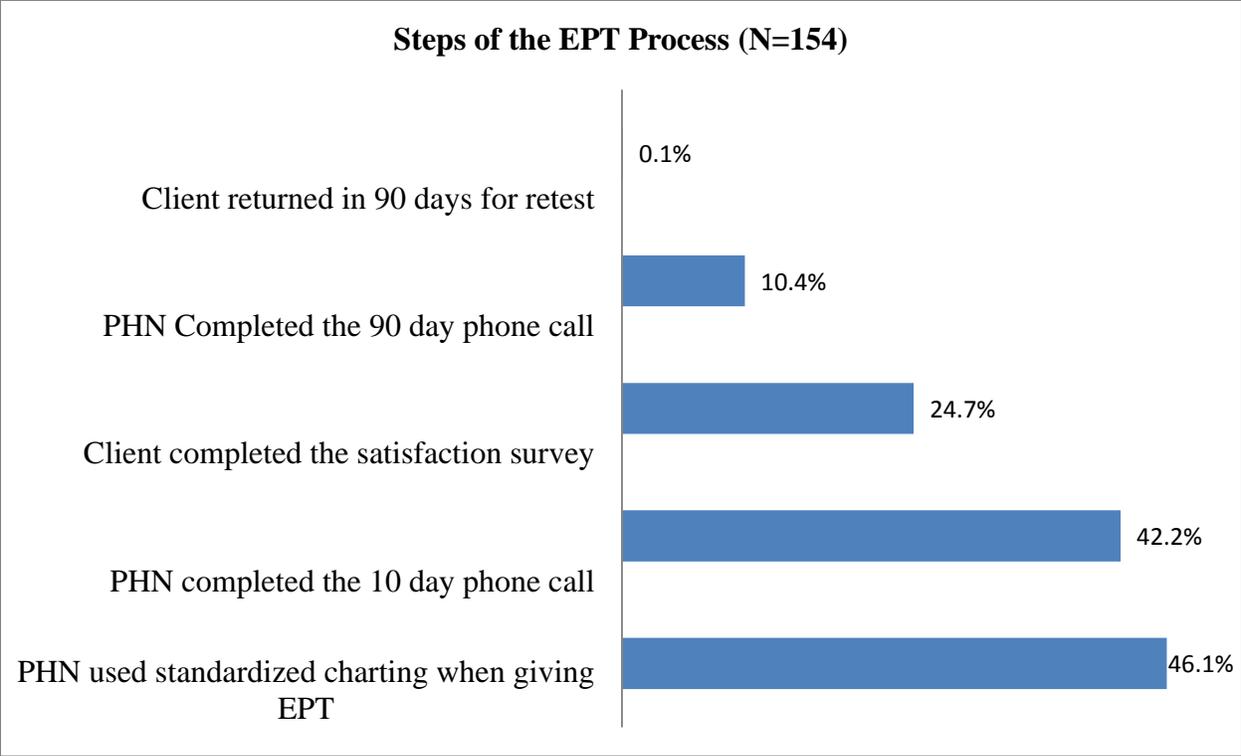
STD	N (total)	Sex	N (males)	Sex	N (females)
Positive CT	1,170	Males	485	Females	685
Positive GC	145	Males	90	Females	55
Total Positive CT and/or GC	1,315	Males	575	Females	740

Of the 1,315 clients with positive lab test for CT/GC, EPT services were documented as either declined or given in 180 charts (13.7%). However, of the 180 clients who were offered EPT, 154 (85.6%) accepted and only 26 (14.4%) declined (Figure 2).



**Figure 3: Public Health Nursing Clients Accepting/Declining EPT When Offered, N=180**

The process for delivery of EPT included steps over a 90 day period of time following the initial clinic appointment. These steps include standardized documentation of EPT service, phone call to ensure the client gave the medication to his/her partner after 10 days, a client satisfaction survey during the 10 day phone call, a reminder call at 90 days to return for retest, and the retest appointment 90 days after EPT was given. With each step of the process, completion rates declined (Figure 3).



**Figure 4: Steps of the EPT Process Completed for Public Health Nursing (N=154)**

Clients are eligible for EPT services as long as they are not in an interpersonal violence (IPV) situation, as disclosure of an STD to their partner could escalate violence. It is also not recommended for men having sex with men (MSM) due to the high risk of concurrent STDs such as Hepatitis C and Human Immunodeficiency Virus (HIV). These individuals are encouraged to come to the clinic for further testing and treatment. The SOPHN rate of IPV disclosure is 1.25% of all clients receiving clinical services, and PHNs do not see a large number of MSM individuals. Therefore, the rate of 180 out of 1,315 (13.7%) clients with positive CT/GC labs who were offered EPT and either accepted it or declined was very low. However, it could be a matter of documentation as well, especially for those who declined the service. It could also be explained if the partner had already been treated, the partner was in the clinic with them today or had already been treated, they prefer the medication be delivered by the clinician,

or they were no longer with their partner (Vaidya, Johnson, Rogers, Nash & Schillinger, 2014). In each of these scenarios, EPT would not be appropriate and therefore would not be offered or declined.

The SOPHN process for follow up of EPT clients by PHNs includes a phone call at about 10 days following the EPT appointment to assess if the medication was given or not. Only 65 of the 154 EPT clients (24.7%) were called and had documentation according to standardized charting. During this call, two questions were asked to assess client satisfaction. The overall number of clients with documented satisfaction surveys was 38 out of 154 (24.7%).

Out of the 38 clients who responded to the questions, client satisfaction was very high. A total of 97.4% of clients felt prepared to give their partner the medication, and 94.7% stated that using EPT was a good option for them.

The CDC recommends a test of reinfection be done about 90 days after a client receives treatment for CT and/or GC, regardless of whether they accept EPT or not. Standardized charting for this appointment was part of the education and plan for this service. A total of 16 of the 154 EPT clients (10.1%) had been called to remind them of this retest, and there was only one documented retest lab done in the clinic. However, 36.4% of clients did have another CT/GC lab test in the clinic within one year for other reasons including symptoms of STI, contact to an STI or routine testing. Of these 26.8% were positive for an STI, and 71.4% were now negative.

### **Focus Group Discussion Results**

The FGD was facilitated to open the discussion about use of EPT and to identify potential barriers. The group included six of the seven public health nurses who were part of the original

planning committee. One member has since left public health nursing and did not participate. The discussion was conducted using webinar technology as the participants are from all four regions and located around the state of Alaska.

Several themes were identified using thematic analysis upon reviewing the recorded guided discussion, such as overall underutilization of EPT, process deviation, and EPT process management. The first theme that emerged was on underutilization of EPT overall. One comment from a team member was “I don’t think it is being used to the extent that it should be used. Just looking at the numbers for how much it is used and how much CT there is in AK I don’t think it is being used enough.” Another PHN stated “I think my initial thoughts were that it would start off very slowly in terms of uptake but would gradually start to increase as staff becomes more familiar with the process...But when we put together the information for the CDC, their feedback to us was that slow uptake is what they’ve seen in other states but when nurses became more comfortable with the process it goes up. And it surprised me we haven’t seen that.”

The next theme was process deviation related to a lack of comfort or confidence in the process as it is currently set. One PHN stated “I do think it’s being followed somewhat, there is a lack of comfort with it on the PHN side which is probably why it is being underutilized.” Another comment was “As a nurse, I still have a hard time wrapping my head and I talked a lot with other team members about this. How can I do this, who would qualify...One of the barriers to me would be still in my head figuring out who would be the candidate?”

The final theme was regarding EPT process management. All PHNs were trained to follow a set of steps as defined by policy for each EPT client. This process included standardized

charting for all encounters, a phone call at 10 days, and a test of reinfection at 90 days. One comment reflected an initial strong start to introducing staff to EPT: “In the beginning I was talking with my NMs [nurse managers] with questions, but we haven’t been doing that lately. My assumption is that the process is being followed.” Another PHN stated “I am not in the clinic but I am doing a lot of chart audits so I should be able to tell, and it doesn’t look like a lot of clients are being assessed”. Finally, one statement was “But are they assessing everyone that comes in that could use it, [then I would say] no.”

### **Online Survey of Public Health Nurses**

Survey Monkey was used to collect information from the clinic PHNs and managers (see Appendix B). The objective was to identify barriers, strengths and weaknesses of the current EPT program and process. Due to vacancies, there were a total of 97 PHNs at the time of the online survey. Of these, 55 surveys were completed and collected, resulting in a 56.7% response rate. Of those who participated, 90% had completed the live or recorded training on providing EPT, and of those trained, 88.6% felt they were prepared to use EPT in their clinical practice.

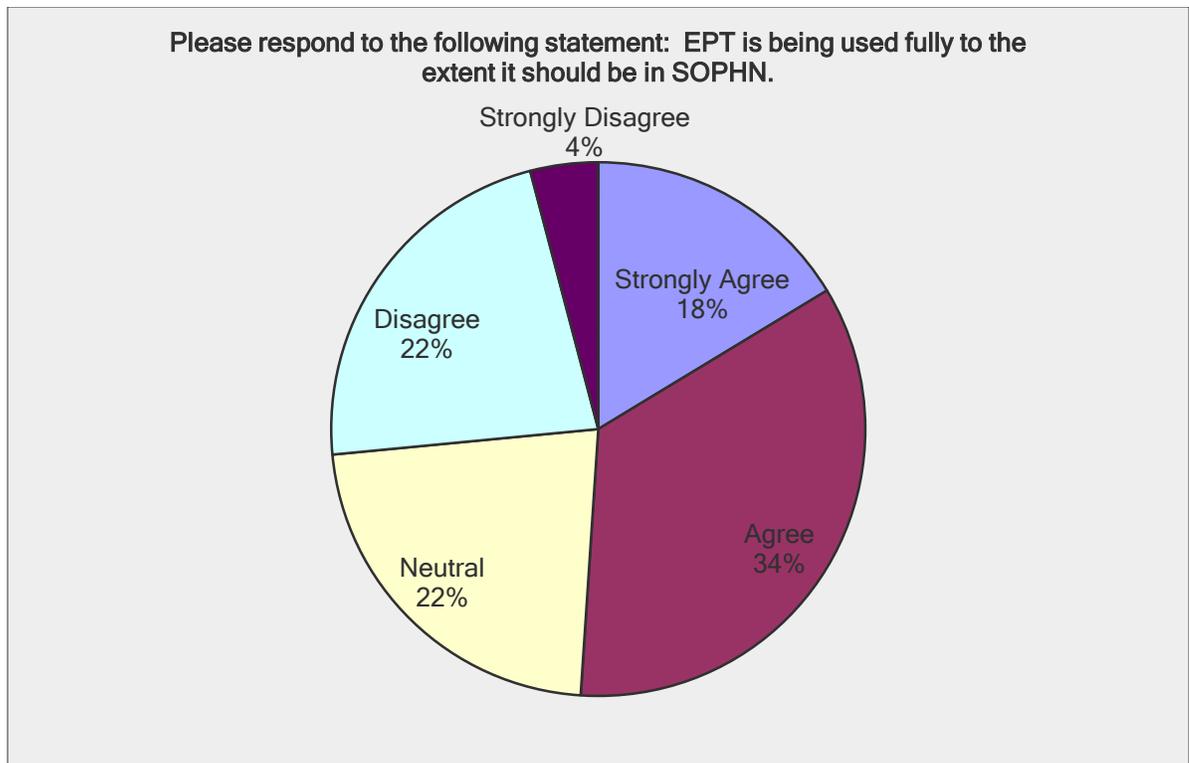
Approximately 39% (38.8%) of respondents had never given EPT to a client, indicating there may be some practical reasons and barriers in providing EPT. These PHNs were then asked why they had not given EPT medications to a client. Reasons and barriers listed from the 19 PHNs who have never given EPT are shown in Table 2.

**Table 2: Reasons Given by Public Health Nurses for why EPT was Never Given**

<b>Reasons why the PHN had not given EPT</b>	<b>Response Count (N=19)</b>	<b>Response Percent</b>
I have not seen a client with a positive STI	13	68.4%
My clients have all declined EPT	5	26.3%
I have not been trained in STI/EPT services	2	10.5%
My position is not clinical	2	10.5%
Partners have confirmed treatment at other clinics	1	5.3%
I don't believe in EPT	0	0.0%

One survey comment was that they had not given EPT because they had been able to successfully elicit partner names. Another stated that there were too many rules in order to give EPT.

When asked if they felt EPT was being used fully to the extent it should be in SOPHN, only 52% (29) agreed/strongly agreed. Another 22% (12) were neutral, and 26% (14) disagree/strongly disagree.



**Figure 5: Public Health Nursing Perception of Utilization of EPT in SOPHN (N=55)**

Specific barriers to use were then elicited from the respondents. Respondents were given a list of the steps per policy for providing EPT to clients, and asked to rate the difficulty in completing each step (No barrier, moderate barrier, strong barrier). There was also the option to answer “I have never done this”, for PHNs who had not given EPT to clients (Table 3).

**Table 3: Barriers in EPT Process for Public Health Nurses (n=49)**

<i>Statement</i>	<i>Barrier</i>	<i>No Barrier</i>	<i>Never Done</i>
Completing the 90 day retest appointment	23 (46.9%)	9 (18.3%)	17 (34.7%)
Developing a reminder system for tracking the EPT process	22 (44.9%)	12 (24.5%)	15 (30.6%)
Completing the 10 day phone call	19 (38.8%)	15 (30.6%)	15 (30.6%)
Completing the 90 day phone call	19 (38.8%)	14 (28.6%)	16 (32.7%)
Standardized charting 10 day phone call	17 (34.7%)	17 (34.7%)	15 (30.6%)
Standardized charting 90 day retest	19 (38.8%)	14 (28.6%)	16 (32.7%)
Providing EPT medications for named partners	10 (20.4%)	31 (63.3%)	8 (16.3%)
Defining Eligible clients for EPT Services	10 (20.4%)	30 (61.2%)	9 (18.3%)
Explaining EPT services to clients	2 (4.0%)	39 (80.0%)	8 (16.2%)

Other concerns included a decrease in the opportunity to screen for other STIs because of the missed opportunity to see the contacts in the clinic. There was also mention that PHNs should first attempt to encourage partners to come in for an appointment to get the best care, and that EPT should be a last resort for those who cannot or will not come in for treatment. Another comment was that clients would keep the medication and take it when they think they have CT/GC symptoms again.

Barriers for using EPT can often be provider beliefs and concerns (Golden & Estcourt, 2011). These reasons can be fear of antimicrobial resistance, allergic reactions and legal recourse, as well as internal concerns of increased clinical time and difficulty following procedures. Provider hesitancy in offering and using EPT with their clientele was then addressed (Table 4).

**Table 4: Other Concerns/Barriers for EPT Use by Public Health Nurses (N=49)**

<b>Answer Options</b>	<b>Response Percent</b>	<b>Response Count</b>
Increased amount of clinical time to use EPT instead of traditional contact investigation	6.3%	3
Difficulty tracking client through the 90 day retest appointment	60.4%	29
Difficulty following standardized charting for EPT	8.3%	4
Fear of giving medications due to potential allergic reaction	35.4%	17
Fear it would increase antimicrobial resistance	12.5%	6
Concerns regarding the legal aspects of EPT	12.5%	6
No other concerns in using EPT	29.2%	14
Other (please explain)		8

Again, 60.4% cited the difficulty of tracking clients through the 90 day retest appointment as a major concern. Another 35.4% have a fear of an allergic reaction in the partner. Additionally 12.5% of PHNs stated concerns with increasing antimicrobial resistance as well as a fear over the legality of providing EPT in Alaska.

Finally, participants were asked to list recommendations for improving the EPT process. Suggestions included building a report into RPMS to include training for PHNs on how to use the report as a tool for identifying clients due for 10 day or 90 day follow up. There were four comments that suggested annual training; and, specifically to address concerns and possible barriers for PHNs to provide EPT services. Finally, there were requests to simplify the process to make it easier to follow the process or reduce the number of steps overall.

## Chapter 5: Discussion

The results of this process evaluation indicate that the uptake of EPT services by PHNs is lower than expected or desired. As mentioned in the results section, of the 1,315 clients with positive lab test for CT/GC, EPT services were documented as either declined or given in 180 charts (13.7%). A large study of CT infected individuals in New York City from 2011 to 2012 demonstrated an uptake rate for use of EPT for partner notification of 54.4% (Vaidya, Johnson, Rogers, Nash & Schillinger, 2014). This indicates that use of EPT in public health in Alaska is underutilized. Barriers to using EPT in the clinic can be summarized as difficulty following the process and provider concerns and hesitancy.

Of 1,315 positive labs for CT and GC only 180 had documented that EPT was offered, and subsequently declined or given. Most clients that are seen at the clinics are eligible for the services, since only those who disclose IPV or are men having sex with men are ineligible. Less than 2% of clients disclose IPV, and we do not see a high number of MSM clients; so there should be a much higher rate of EPT declines. Therefore, the PHN is either not offering EPT to all eligible clients, or they are not documenting it using standardized charting. Another reason could be that the client's partner is with them in the clinic that day, or that they were treated already. Finally, clients may decline EPT if they are no longer with their partner. In the study by Vaidya, Johnson, Rogers, Nash & Schillinger, 2014, "excluding person whose partners were already treated and person whose partners were in the clinic for treatment, EPT acceptance rates were 69.4%."

Of the staff responding to the survey, a high number (38.8%) have never given EPT medications to a client. Possibly, there may be super-users, or staff who are more comfortable

with using EPT than others. Because of staff turnover, there is also a large cohort of new PHNs around the state who may not have been trained in treatment for STD's or in using EPT yet. Another reason listed by survey participants was they had not seen a client with a positive STD (68.4%). Some areas in Alaska have a lower incidence of STDs, as well as more community partners who offer this service such as Tribal Health, private providers and Planned Parenthood clinics. Also, some health centers have PHNs in certain clinical areas that may not include STI/EPT, such as child health or home visiting services.

Clearly the process is complicated and long, with tracking the client from the time of treatment through the 90 day retest. Original plans were to develop a weekly database report that would list all of the EPT clients who were due for the 10 day phone call and the 90 day retest. This report is not yet functioning and tracking the clients is problematic. A few health centers have Health Program Associates (HPA), non-licensed personnel that can assist with tracking and calling clients. Some health centers are leaving the tracking up to the PHN who saw the client, and the individual PHNs are using paper or electronic ticklers that they have designed. Other health centers have a "nurse of the day" who is responsible for calling clients who are due to be seen. Clearly with low rates of 10 day phone calls and 90 day retests, this process is not working well. The Nurse Informatics team has developed a report that can be helpful, but it is not easy to follow and is underutilized by staff. Finally, with a highly transient population around the state of Alaska, locating clients 90 days after an appointment can be challenging.

Although the literature clearly shows that allergic reactions to the medications given for EPT treatment are extremely low, this continues to be a barrier for a significant number of staff. The risk of increasing antimicrobial resistance is also a concern, but literature reviews show that

this is not occurring and should not be a barrier to EPT. Finally, concerns over the legality of EPT in Alaska were listed although updated laws make it clear that it is legal for use in Alaska.

## **Chapter 6: Strengths and Limitations**

A noteworthy limitation of this study was the small numbers and size of the data sets. Also, because of a recent large amount of staff turnover, many of the new PHNs had not been trained in STD or EPT services in the clinic, and therefore did not have an opportunity to offer EPT to clients during the data collection period of this study. Finally, STDs are more common in some of the regions around Alaska, and less common in others. Some of the smaller clinics see a very limited number of positive CT or GC cases.

Time was also a limitation as this quality improvement process was needed by the SOPHN to make decisions in the use of EPT with their clientele. A longer study that looked at process over time would have been useful to see if there has been any increase in uptake of EPT services.

There were several methods used to gather the data in this program evaluation. If only one method had been used it may have produced more focused data and could have been more easily summarized. In retrospect, the FGD data were most valuable and could have been conducted with several groups including PHNs who are treating clients with positive STDs. It may have more strongly identified barriers of using EPT and ways to improve the process in the future.

## **Chapter 7: Public Health Implications**

The use of EPT in treating partners with positive CT and GC infections has been shown to be highly effective in reducing reinfection and in decreasing the amount of time for contacts to be treated. Public health is currently challenged with budget cuts and staffing issues in Alaska. Resources for conducting traditional confidential contact investigations are limited. There are only three Health Program Associates (HPAs) with nursing, located in Fairbanks, Mat-Su and Nome. These non-licensed personnel are able to assist the nursing staff with contacting positive clients and eliciting names of partners, as well as phone follow up for referrals and treatments, including EPT. In the Section of Epidemiology, there are four Disease Intervention Specialists (DIS) located in Anchorage who are able to complete contact investigations. This makes it is more difficult for them to make contact within rural areas, so they often rely on public health nurses to do this work. The Alaska Native Tribal Health Consortium has one DIS worker to do any follow up work with their clientele. Finally, the Municipality of Anchorage Public Health Nursing has several nurses who rotate this role that comprises about 1.0 full-time position. The small number of these specialists and the limited number of PHNs in the state demonstrate we clearly are not able to effectively complete traditional contact investigations on all positive CT and GC clients in the state.

The use of EPT is an additional partner management tool to prevent and control STDs, and could be a big savings of time over doing confidential contact investigations when used with eligible clients in our clinics. Golden et al. (2006) found the percentage of cases classified as having all of their partners treated increased from 39% to 65% with the introduction of an EPT program in King County, Washington. Also, treating contacts more rapidly by providing EPT may decrease the prevalence of the disease thereby interrupting the spread of the disease.

This study identified barriers in the process used by PHNs to provide EPT to their clients. The online survey revealed some perceived barriers in staff attitude and knowledge surrounding the use of EPT in their clinical practices, such as the misperception that EPT may cause increased antimicrobial resistance or large numbers of severe allergic reactions. These lessons can be used as a basis for a quality improvement project including continued education within the Section of Public Health Nursing. The information (or data) can also be used by other providers considering implementing EPT in their practice.

## **Chapter 8: Conclusion and Recommendations**

As stated in the introduction, the use of EPT is effective in reducing reinfection for clients with a positive CT or GC test. Most clients getting services with the SOPHN are eligible for EPT and should be offered this option for treating their sexual contacts. However, uptake of EPT services has been slow. Because dates of services were not available, it is not possible to determine if EPT services have increased over time. Barriers have been identified and are divided into two major categories, program process and provider knowledge and comfort.

There are ways to improve the process of EPT provision by making it less difficult for staff to understand and to complete. Listed below are some of the recommendations that will be put forward to SOPHN leadership team as a result of this study:

1. Offer education on EPT annually to staff addressing perceived barriers of concerns over possible allergic reactions and/or increasing microbial resistance. Provide the evidence based literature that addresses legal concerns.
2. Form a quality improvement workgroup to assess the current process and policy, and to build in continuous evaluation of the program over time.
3. Ask the client how many contacts they have had in the past two months and provide them EPT for each one without requiring them to disclose names of partners. This will add an additional layer of confidentiality for clientele who may be hesitant to name certain contacts, but would be willing to give them the medications if provided.
4. Work closely with the Informatics Team to develop an electronic tracking tool in RPMS to help PHNs follow the policy through the 90 day retest appointment more easily and consistently around the state.

5. Review records of EPT given by provider to identify if there are super users who could be champions in their clinic and/or region in increasing EPT use by other PHNs.
6. Investigate alternate ways to contact the client in 10 and 90 days besides by phone. Some ideas might be private messenger, email, regular mail or texting.
7. Ensure that future evaluation includes gathering data by region and by date. This will show if there is better uptake of EPT by geographical area or health center, as well as if there is an increase in use of EPT over time by the PHNs.

Finally, it is recommended that a workgroup be formed to begin a quality improvement process that would include an annual review of the EPT program. A benchmark should be considered to track the uptake of EPT use in the clinics. Managers should review which nurses are using EPT and which may not be using it due to barriers and/or educational needs. They should work closely with their staff to support the EPT program uptake.

## References

- Burstein, G. R., Eliscu, A., Ford, K., Hogben, M., Chaffee, T., Straub, D., et al. (2009). Expedited partner therapy for adolescents diagnosed with chlamydia or gonorrhea: A position paper of the society for adolescent medicine. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, 45(3), 303-309. doi:10.1016/j.jadohealth.2009.05.010 [doi]
- Cecere, D., & Jones, S. (2014, June 18). Chlamydial infection - Alaska, 2013. State of Alaska Epidemiology Bulletin. Retrieved from [http://www.epi.hss.state.ak.us/bulletins/docs/b2014\\_10.pdf](http://www.epi.hss.state.ak.us/bulletins/docs/b2014_10.pdf)
- Cecere, D., & Jones, S. (2010, June 11). Could expedited partner therapy work in Alaska? A call for health care provider and patient input. *State of Alaska Epidemiology Bulletin*. Retrieved from [http://www.epi.hss.state.ak.us/bulletins/docs/b2010\\_15.pdf](http://www.epi.hss.state.ak.us/bulletins/docs/b2010_15.pdf)
- Cecere, D., Senft, S., Jones, S. (2011, January 12). Expedited partner therapy recommendations for Alaska providers. *State of Alaska Epidemiology Bulletin*. Retrieved from [http://www.epi.hss.state.ak.us/bulletins/docs/b2011\\_01.pdf](http://www.epi.hss.state.ak.us/bulletins/docs/b2011_01.pdf)
- Cecere, D., & Jones, S. (2014, June 18). Gonococcal infection - Alaska, 2013. State of Alaska Epidemiology Bulletin. Retrieved from [http://www.epi.hss.state.ak.us/bulletins/docs/b2014\\_11.pdf](http://www.epi.hss.state.ak.us/bulletins/docs/b2014_11.pdf)
- Centers for Disease Control and Prevention. (2012). Guidance on the use of expedited partner therapy in the treatment of gonorrhea. Retrieved November 16, 2014, from <http://www.cdc.gov/std/ept/gc-guidance.htm>
- Centers for Disease Control and Prevention. (2014). *Chlamydia*. Retrieved December 19, 2014, from <http://www.cdc.gov/std/chlamydia/default.htm>
- Golden, M. R., Brewer, D., Holmes, K., Whittington, W., Hogben, M., & Handsfield, H. (2007). Evaluation of a population-based program of expedited partner therapy for gonorrhea and chlamydial infection. *Sexually Transmitted Diseases*, 34(8), 598-603.
- Golden, M. R., & Estcourt, C. S. (2011). Barriers to the implementation of expedited partner therapy. *Sexually Transmitted Infections*, 87 Suppl 2, ii37-8. doi:10.1136/sti.2010.047670 [doi]
- Hogben, M., Kidd, S., & Burstein, G. R. (2012). Expedited partner therapy for sexually transmitted infections. *Current Opinion in Obstetrics & Gynecology*, 24(5), 299-304. doi:10.1097/GCO.0b013e3283577e9d [doi]
- Kissinger, P. J. (2014). Expedited partner therapy for sexually transmitted diseases--are we there yet? *Sexually Transmitted Diseases*, 41(11), 695-697. doi:10.1097/OLQ.0000000000000207 [doi]

- Mears, C., Kelly, T., Kaviany, S., Reggi, J., & Amidon, M. (2014). Expedited partner therapy and STI awareness. *Journal of Adolescent Health, 54*(2), S63.
- Radovic, A., Burstein, G. R., Marshal, M. P., Murray, P. J., Miller, E., & Sucato, G. S. (2013). Adolescents' attitudes toward expedited partner therapy for sexually transmitted infections. *Sexually Transmitted Diseases, 40*(11), 894-897. doi:10.1097/OLQ.0000000000000034 [doi]
- Sheaves, C. (2012). Sexually transmitted infection updates: Recommendations from the CDC. *The Nurse Practitioner, 37*(9), 43-46. doi:10.1097/01.NPR.0000418383.06606.d8 [doi]
- Teplow-Phipps, R., Stockwell, M. S., & Soren, K. (2015). Adolescent chlamydia infection: Treatment, expedited partner therapy, and testing for reinfection. *Clinical Pediatrics, doi:0009922814566934* [pii]
- Torrone, E. A., Keck, J. W., Cecere, D., & Jones, S. A. (2011, January 12). An assessment of expedited partner therapy for enhanced gonorrhea and chlamydia control in Alaska. *State of Alaska Epidemiology Bulletin*. Retrieved from [http://www.epi.hss.state.ak.us/bulletins/docs/rr2011\\_01.pdf](http://www.epi.hss.state.ak.us/bulletins/docs/rr2011_01.pdf)
- Vaidya, S., Johnson, K., Rogers, M., Nash, D., & Schillinger, J. A. (2014). Predictors of index patient acceptance of expedited partner therapy for *Chlamydia trachomatis* infection and reasons for refusal, sexually transmitted disease clinics, New York City, 2011 to 2012. *Sexually Transmitted Diseases, 41*(11), 690-694. doi:10.1097/OLQ.0000000000000197 [doi]

## Appendix A: CITI Certification for Principal Investigator

**COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI)  
BASIC/REFRESHER COURSE IN HUMAN SUBJECTS RESEARCH CURRICULUM COMPLETION REPORT**  
Printed on 08/05/2014

**LEARNER** Colleen McNulty (ID: 2070501)  
**DEPARTMENT** Health Sciences  
**PHONE** 907-334-2267  
**EMAIL** csee1@uaa.alaska.edu  
**INSTITUTION** University of Alaska Anchorage  
**EXPIRATION DATE** 08/04/2017

**UNIVERSITY OF ALASKA ANCHORAGE FACULTY, STAFF AND STUDENTS**

**COURSE/STAGE:** Refresher Course/2  
**PASSED ON:** 08/05/2014  
**REFERENCE ID:** 11842668

REQUIRED MODULES	DATE COMPLETED	SCORE
Biomed Refresher 2 - Instructions	06/13/14	No Quiz
Biomed Refresher 2 – History and Ethical Principles	06/13/14	3/3 (100%)
Biomed Refresher 2 – Regulations and Process	06/13/14	2/2 (100%)
Biomed Refresher 2 – Informed Consent	08/05/14	3/3 (100%)
Biomed Refresher 2 – SBR Methodologies in Biomedical Research	08/05/14	4/4 (100%)
Biomed Refresher 2 – Genetics Research	08/05/14	2/2 (100%)
Biomed Refresher 2 – Records-Based Research	08/05/14	3/3 (100%)
Biomed Refresher 2 – Research Involving Vulnerable Subjects	08/05/14	1/1 (100%)
Biomed Refresher 2 – Vulnerable Subjects – Prisoners	08/05/14	2/2 (100%)
Biomed Refresher 2 – Vulnerable Subjects – Children	08/05/14	3/3 (100%)
Biomed Refresher 2 – Vulnerable Subjects – Pregnant Women, Human Fetuses, Neonates	08/05/14	2/2 (100%)
Biomed Refresher 2 – HIPAA and Human Subjects Research	08/05/14	5/5 (100%)
Biomed Refresher 2 – Conflicts of Interest in Research Involving Human Subjects	08/05/14	3/3 (100%)
How to Complete the CITI Refresher Course and Receive a Completion Report	08/05/14	No Quiz

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI Program participating institution or be a paid Independent Learner. Falsified information and unauthorized use of the CITI Program course site is unethical, and may be considered research misconduct by your institution.

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## Appendix B

### Evaluation of a Public Health Nursing Expedited Partner Therapy Program

#### INFORMED CONSENT FORM

<b>Principal Investigator:</b> Colleen McNulty, BSN, RN MPH Student Tel: (907) 334-2267 E-mail: <a href="mailto:colleen.mcnulty@alaska.gov">colleen.mcnulty@alaska.gov</a>	<b>Project Committee Chair/ UAA Faculty:</b> Dr. Nancy A. Nix Tel: (907) 786-6590 E-mail: <a href="mailto:nanix@uaa.alaska.edu">nanix@uaa.alaska.edu</a>
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**DESCRIPTION:**

I am conducting an evaluation of the Expedited Partner Therapy (EPT) program in public health nursing. I will be assessing program fidelity and the implementation process. I am also interested in public health nurses knowledge, satisfaction, attitudes and beliefs regarding the use of EPT in their practice.

**VOLUNTARY NATURE OF PARTICIPATION:**

Your participation in this study is voluntary. If you don't wish to participate, or would like to end your participation in this study, there will be no penalty or loss of benefits to you to which you are otherwise entitled. In other words, you are free to make your own choice about being in this study or not, and may quit at any time without penalty.

**CONFIDENTIALITY:**

Your name will not be attached to your interview responses. Your name and any other identifiers will be kept in a locked file that is only accessible to me or my research associates. Any information from this study that is published will not identify you by name.

**BENEFITS:**

There will be no direct benefit to you from participating in this study. The results of this study may benefit public health nursing as a quality improvement guide.

**RISKS:**

It is possible that the discussion of thoughts or feelings about the use of EPT in public health nursing could make you uncomfortable. However, there are no other known risks to you.

**CONTACT PEOPLE:**

If you have any questions about this research, please contact the Principal Investigator and/or the Project Committee Chair/UAA Faculty at the telephone numbers listed above. If you have any questions about your rights as a research subject, please contact Sharilyn Mumaw, UAA Research Compliance Officer, at (907) 786-1099.

**CONSENT:**

Do you consent to participation in a GoToWebinar meeting as a group to discuss Public Health Nursing and its Expedited Partner Therapy program?

Yes  No

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix C

### Evaluation of a Public Health Nursing Expedited Partner Therapy Program

#### INFORMED CONSENT FORM

<b>Principal Investigator:</b> Colleen McNulty, BSN, RN MPH Student Tel: (907) 334-2267 E-mail: Colleen.mcNulty@alaska.gov	<b>Project Committee Chair/ UAA Faculty:</b> Dr. Nancy A. Nix Tel: (907) 786-6590 E-mail: nanix@uaa.alaska.edu
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**DESCRIPTION:**

I am conducting an evaluation of the Expedited Partner Therapy (EPT) program in public health nursing. I will be assessing program fidelity and the implementation process. I am also interested in public health nurses knowledge, satisfaction, attitudes and beliefs regarding the use of EPT in their practice.

**VOLUNTARY NATURE OF PARTICIPATION:**

Your participation in this study is voluntary. If you don't wish to participate, or would like to end your participation in this study, there will be no penalty or loss of benefits to you to which you are otherwise entitled. In other words, you are free to make your own choice about being in this study or not, and may quit at any time without penalty.

**CONFIDENTIALITY:**

This survey is anonymous and your name will not be associated with any of your responses.

**BENEFITS:**

There will be no direct benefit to you from participating in this study. The results of this study may benefit public health nursing as a quality improvement guide.

**RISKS:**

There are no known risks for your participation in this study.

**CONTACT PEOPLE:**

If you have any questions about this research, please contact the Principal Investigator and/or the Project Committee Chair/UAA Faculty at the telephone numbers listed above. If you have any questions about your rights as a research subject, please contact Sharilyn Mumaw, UAA Research Compliance Officer, at (907) 786-1099.

**CONSENT:**

I consent to participate in this online survey regarding EPT use in public health nursing  
(Click on Yes or No)    Yes    No (if No, then you will be exited from the survey)  
My continuation with this online survey implies my consent to participate in this study.

## **Appendix D: Focus Group Discussion Question Guide**

### Focus Group Discussion Questions

1. Do you think that EPT is being used to the extent it should be in SOPHN?
2. Do you feel the process is being followed when assessing for the use of EPT?
3. Do you feel the process is being followed when providing EPT?
4. What do you perceive as barriers to use of EPT?
5. What questions do you want answered from my EPT program evaluation?

## Appendix E: Online Survey Questions

1. Did you complete the training for providing EPT, either via live webinar or the archived recording?
  - a. Yes
  - b. No
2. Following the education, I felt prepared to use EPT in my clinical practice. (if yes to 1)
  - a. Strongly Agree
  - b. Agree
  - c. Neutral
  - d. Disagree
  - e. Strongly Disagree
3. Have you given EPT medications to a client?
  - a. Yes
  - b. No
4. The reason(s) I have not provided EPT medications to a client are (choose all that apply).  
(if no to 3)
  - a. I have not been trained in STI yet
  - b. I have not been trained in EPT services yet
  - c. I don't believe in EPT
  - d. My clients have all declined EPT
  - e. I have not seen a client with a positive STI
  - f. Other (Please explain)

5. Please respond to the following statement: EPT is being used fully to the extent it should be in SOPHN.
- a. Strongly Agree
  - b. Agree
  - c. Neutral
  - d. Disagree
  - e. Strongly Disagree
6. Please respond to the following statement: Using EPT increases the amount of clinical time vs using traditional contact investigation services.
- a. Strongly Agree
  - b. Agree
  - c. Neutral
  - d. Disagree
  - e. Strongly Disagree
7. Please rate the following possible barriers to using EPT with clients. (Ratings: I have not done this; No barrier; Slight barrier; Moderate barrier; strong barrier)
- a. Defining eligible clients for EPT services
  - b. Explaining EPT services to clients
  - c. Providing EPT medications for named partners
  - d. Developing a tickler system for tracking the EPT process for 90 days
  - e. Completing the 10 day phone call
  - f. Charting the 10 day phone call
  - g. Completing the 90 day phone call for retest

- h. Charting the 90 day phone call for retest
  - i. Completing the 90 day retest appointment
  - j. Charting the 90 day retest appointment
8. What other concerns do you have about using EPT services (check all that apply)?
- a. Increased amount of clinical time to use EPT instead of traditional contact investigation
  - b. Difficulty tracking client through the 90 day retest appointment
  - c. Difficulty following standardized charting for EPT
  - d. Fear of giving medications due to potential allergic reaction
  - e. Fear it would decrease antimicrobial efficiency
  - f. Concerns regarding the legal aspects of EPT
  - g. No other concerns in using EPT
  - h. Other (please explain)
9. What suggestions do you have to improve the EPT process for SOPHN?