

The Legal Aspects of Expedited Partner Therapy Practice: Do State Laws and Policies Really Matter?

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Background: Expedited partner therapy (EPT) is a potential partner treatment strategy. Significant efforts have been devoted to policies intended to facilitate its practice. However, few studies have attempted to evaluate these policies.

Methods: We used data on interviewed gonorrhea cases from 12 sites in the STD Surveillance Network in 2010 ($n = 3404$). Patients reported whether they had received EPT. We coded state laws relevant to EPT for gonorrhea using Westlaw legal research database and the general legal status of EPT in STD Surveillance Network sites from Centers for Disease Control and Prevention's Web site in 2010. We also coded policy statements by medical and other boards. We used χ^2 tests to compare receipt of EPT by legal/policy variables, patient characteristics, and provider type. Variables significant at $P < 0.10$ in bivariate analyses were included in a logistic regression model.

Results: Overall, 9.5% of 2564 interviewed patients with gonorrhea reported receiving EPT for their partners. Receipt of EPT was significantly higher where laws and policies authorizing EPT existed. Where EPT laws for gonorrhea existed and EPT was permissible, 13.3% of patients reported receiving EPT as compared with 5.4% where there were no EPT laws and EPT was permissible, and 1.0% where there were no EPT laws and EPT was potentially allowable ($P < 0.01$). Expedited partner therapy was higher where professional boards had policy statements supporting EPT ($P < 0.01$). Receipt of EPT did not differ by most patient characteristics or provider type. Policy-related findings were similar in adjusted analyses.

Conclusions: Expedited partner therapy laws and policies were associated with higher reports of receipt of EPT among interviewed gonorrhea cases.

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Expedited partner therapy (EPT) is a partner management technique where medications or prescriptions are provided to the partner of a patient who tests positive for chlamydia or gonorrhea without physical examination of the partner. EPT can reduce chlamydia and gonorrhea reinfection^{1–4} and is recommended by the Centers for Disease Control and Prevention (CDC) and other medical and legal organizations.^{5–8} Given the effectiveness of EPT in reducing sexually transmitted disease (STD) reinfections and the low risk of adverse effects associated with its use,⁹ policy efforts have focused on facilitating its practice. To serve as a resource for providers, Hodge and colleagues analyzed state laws and policies relevant to EPT, categorizing the probable legal status of EPT for treating any STD in each state as: permissible, potentially allowable, or prohibited.¹⁰ The primary factors considered were state statutes (laws passed by the legislature), regulations (promulgated by state departments of health or professional licensure boards), and policy statements by state professional licensure boards supporting its practice. This resulted in a “comparative snapshot of legal provisions that may highlight legislative, regulatory, judicial laws and policies concerning EPT.”¹¹

Research has evaluated various aspects of EPT. One study found that EPT is routinely used by family planning providers in California, and most of these providers feel that it improves care.¹² In addition, rates of partner treatment are higher for both concurrent treatment visits (patient and partner treated concurrently) and EPT as compared with standard patient referral.¹³ EPT is cost-effective in certain situations,¹⁴ and changes to clinic policies requiring documentation of EPT have been shown to increase EPT's acceptance.¹⁵ Lastly, provider knowledge of EPT is associated with higher rates of practice, yet practice is inhibited by concern for legal liability.¹⁶ Concern for liability exists because EPT involves prescribing and dispensing medications to individuals who have not been physically examined by a health care provider. Potential legal actions include medical malpractice lawsuits from individuals or censure from state professional licensure boards.¹⁰

Concern for legal liability is considered one of the primary impediments to the practice of EPT,¹⁰ and despite policy initiatives intended to clarify its legal status, the effect of these laws and policies on the provision of EPT has not been evaluated.

Therefore, this study investigates the relationship between laws and policies and the practice of EPT by comparing the receipt of EPT by patients with gonorrhea in Sexually Transmitted Disease Surveillance Network (SSuN) participating sites across states of varying legal environments.

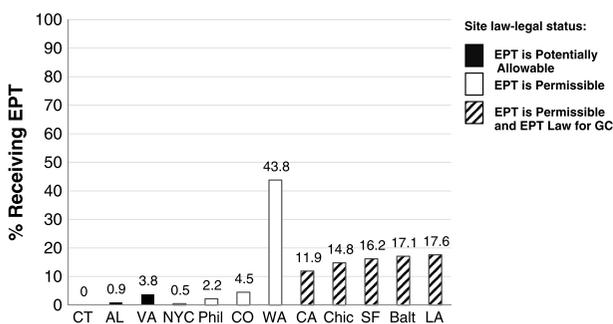
MATERIALS AND METHODS

Study Design

We used several sources to assess the relationship between legal and policy aspects of EPT and receipt of EPT among reported cases of gonorrhea in the United States. For the legal and policy variables, we used the Westlaw legal research database (Thompson Reuters, New York, NY) and the probable legal status for each state as listed on CDC's Web site to categorize states.¹¹ These data were merged with data collected in 2010 from the 12-site SSuN, which includes STD programs in health departments in the 4 US Census regions (Fig. 1). Each site interviewed a random sample of individuals diagnosed as having gonorrhea from cases reported to the health department. Cases were randomly assigned into the sample when entered into the surveillance system or were randomly selected from the reported cases weekly or biweekly. All sites include at least one county (refer to Fig. 1 for a list of counties), and cases were eligible for sampling if reported within 30 days of diagnosis. Interviews were conducted by telephone, and respondents were asked a series of questions about their gonorrhea diagnosis.

Measures

We used 3 measures to assess the legal and policy aspects of EPT as of January 1, 2010: (1) a combined variable of the general determination of state legal status for EPT as shown on



*Data were weighted for site sampling fraction and non-response.

†California and San Francisco are independently funded and operated SSuN sites.

Figure 1. Receipt of EPT among interviewed patients with gonorrhea by SSuN site, 2010 (n = 2564; data were weighted for site sampling fraction and nonresponse). Counties sampled by site include the following: Alabama, Jefferson County (AL); Baltimore, Baltimore City (Balt); California, all counties excluding San Francisco County (CA; California and San Francisco are independently funded and operated SSuN sites); Chicago, Cook County (Chic); Colorado, Adams, Arapahoe and Denver counties (CO); Connecticut, Hartford and New Haven counties (CT); Louisiana, Orleans Parish (LA); Philadelphia, Philadelphia County (Phil); New York City, Kings, Queens, Bronx, Richmond, New York counties (NYC); San Francisco, San Francisco County (SF); Virginia, Chesterfield and Henrico counties and Richmond City (VA); and Washington, all counties (WA).

CDC's Web site (based on legal research conducted by Hodge and colleagues¹⁰) and state laws that explicitly authorize EPT for gonorrhea (law-legal status), (2) state medical board statements relevant to EPT, and (3) state nonmedical board (eg, pharmacy board) statements relevant to EPT. Using EPT laws specific to gonorrhea from Westlaw and the probable legal status of EPT as displayed on CDC's Web site, we coded the primary legal variable, law-legal status, into the following categories: (1) has law authorizing EPT for gonorrhea and is listed as permissible on CDC Web site (gonorrhea [GC] EPT law and CDC permissible), (2) does not have law authorizing EPT for gonorrhea but is listed as permissible on CDC's Web site (no GC EPT law and CDC permissible), and (3) does not have law authorizing EPT for gonorrhea and is listed as potentially allowable on CDC's Web site (no GC EPT law and CDC potentially allowable; Fig. 2). We used the legal status of EPT as shown on CDC's Web site as a measure of the general legal context of EPT for each state. We considered only those authorities that carry the force of law (eg, statutes and regulations) to be "laws" for this variable.

We also coded policy variables indicating whether a state medical board or other nonmedical board had released a policy statement that would influence the provision of EPT. Although these policy statements do not carry the force of law, they are, nonetheless, presumptive of the legal status of EPT in a state and provide a strong indication of the likelihood that a board would censure a licensee for practicing EPT. For our purposes, "non-medical board" meant any professional board or organization other than the entity responsible for licensing physicians, including entities such as boards of pharmacy and state medical associations. The policy statement variables were coded as (1) yes, statement prohibits EPT; (2) yes, statement permits EPT; and (3) no statement influencing EPT. EPT laws and policies did not change during the study period in any SSuN site.

Our outcome of interest was receipt of EPT. As part of the SSuN interviews, patients with gonorrhea were asked if they were given medication or a prescription for their sex partners using the following response options: (1) no; (2) no, partner(s) was already treated; and (3) yes. Respondents who reported that their partner(s) was already treated were considered ineligible for EPT; therefore, our final outcome measure was dichotomous (yes/no). One site (San Francisco) used different coding (yes/missing) for this variable that we recoded as yes/no; therefore, our estimate of EPT in this site should be interpreted as a minimum estimate.

In addition, SSuN interviews with patients with gonorrhea collected information on patient characteristics and provider type. Demographics examined in our analysis included patient age (limited to those 15–59 years old), race/ethnicity, education, sex/sexual behavior (women; men who have sex with men, or MSM; men who have sex with women, or MSW), and recent incarceration history (past 12 months). Although EPT is not routinely recommended for MSM because it might inhibit diagnosis and treatment of coexisting infections,⁵ our purpose was to examine the actual implementation of EPT in areas with different legal environments rather than evaluating adherence to CDC guidelines. Therefore, we included MSM in our analyses. In addition, respondents were asked about other STDs (previous gonorrhea diagnosis in the past 12 months and coinfection with chlamydia during current gonorrhea diagnosis) and were asked if they had used crack cocaine or methamphetamines in the past 12 months. Respondents reported their number of sex partners in the past 3 months and were asked several questions about sexual risk in the past 12 months, including the following: had anonymous sex partner, met sex partner on internet, exchanged sex for money/drugs, and had

TABLE 1. Receipt of EPT Among Interviewed Gonorrhea Cases by Site Legal Status, Patient Characteristics, and Provider Type (n = 2564): Bivariate and Adjusted Analyses

Correlates	Bivariate Analyses			Adjusted OR (95% CI)
	Unweighted, n	Weighted, % (SE)	P	
Legal/policy issues				
Site law-legal status			<0.01	
GC EPT law and CDC permissible	1201	13.3 (3.3)		23.2 (6.0–89.8)
No GC EPT law and CDC permissible	984	5.4% (2.1)		7.3 (1.7–30.7)
No GC EPT law and CDC potentially allowable	379	1.0% (0.5)		1.0
Patient characteristics				
Age, y			0.94	—
15–19	597	8.0 (3.2)		
20–24	810	9.7 (2.7)		
25–34	691	8.9 (2.0)		
35–59	400	8.4 (2.9)		
Race/ethnicity			0.06	
White (non-Hispanic)	495	12.4 (2.7)		1.4 (0.8–2.5)
Black (non-Hispanic)	1414	9.7 (2.6)		1.0
Hispanic	458	5.9 (2.1)		0.5 (0.3–1.1)
Other	152	14.4 (4.1)		1.5 (0.7–2.9)
Education level			0.27	—
<High school	551	9.0 (3.4)		
High school/GED	809	7.2 (2.1)		
Some college	681	10.3 (2.6)		
College or higher	315	5.3 (2.1)		
Incarcerated (past 12 mo)			0.96	—
No	2266	9.3 (2.0)		
Yes	253	9.5 (4.0)		
Sex/Sexual behavior			0.01	—
Men				
MSM	620	7.5 (2.7)		0.3 (0.2–0.7)
MSW	734	5.8 (1.9)		0.4 (0.2–0.8)
Women	1190	13.7 (3.2)		1.0
Previous gonorrhea diagnosis (past 12 mo)			0.55	—
No	2114	8.6 (2.0)		
Yes	286	10.8 (4.4)		
Coinfected with chlamydia			0.76	—
No	1352	13.0 (3.2)		
Yes	616	12.1 (2.6)		
No. sex partners (past 3 mo)			0.81	—
1	1184	10.6 (2.8)		
2	617	9.1 (3.3)		
≥3	623	8.5 (2.9)		
Had anonymous sex partner (past 12 mo)			0.68	—
No	1936	9.9 (2.5)		
Yes	445	7.7 (4.3)		
Met sex partner via Internet (past 12 mo)			0.72	—
No	1866	7.5 (1.9)		
Yes	330	6.6 (2.9)		
Exchanged sex for money/drugs (past 12 mo)			0.73	—
No	2358	9.5 (2.2)		
Yes	70	8.2 (4.2)		
Had recently incarcerated partner (past 12 mo)			0.07	1.0
No	2098	8.7 (2.1)		
Yes	272	13.7 (4.9)		1.1 (0.6–1.7)
Used crack cocaine (past 12 mo)			0.88	—
No	2343	9.1 (2.1)		
Yes	81	8.8 (2.9)		
Used methamphetamines (past 12 mo)			0.99	—
No	2323	9.1 (2.1)		
Yes	101	9.1 (4.2)		
Provider type			0.42	—
STD clinic	716	9.7 (4.0)		
Reproductive health (FP/GYN)	369	15.2 (5.9)		
ER/Urgent care	247	7.6 (2.7)		

(Continued on next page)

TABLE 1. (Continued)

Correlates	Bivariate Analyses			Adjusted OR (95% CI)
	Unweighted, n	Weighted, % (SE)	P	
Hospital other	277	6.2 (2.2)		
HMO/private	394	6.0 (1.6)		
Public/community health center	222	9.0 (3.6)		
Other	252	11.8 (3.6)		

Past 3 months refers to the 3 months before current gonorrhea diagnosis. Among women, there was no difference in receipt of EPT by pregnancy status. n adjusted analyses = 2323.

FP indicates family planning; GED, General Educational Development test; Gyn, gynecologist; HMO, health maintenance organization.

followed by blacks (9.7%), Hispanics (5.9%), and other racial/ethnic groups (14.4%; *P* = 0.06). The receipt of EPT also differed based on the sex of the patient's sex partner, with MSM receiving EPT 7.5% of the time, MSW receiving EPT 5.8% of the time, and women receiving EPT 13.7% of the time (*P* < 0.01). Lastly, patients who had a recently incarcerated sex partner (past 12 months) had higher reports of receiving EPT (13.7%) did than those not having such a partner (8.7%; *P* = 0.07).

Among states that do not have a law authorizing EPT for gonorrhea, the receipt of EPT differed based on state medical board or other nonmedical board policy statements relevant to EPT (Table 2). In states with medical board policy statements permitting EPT, patients with gonorrhea received EPT at a significantly higher rate (24.4%) than in states with medical board policy statements prohibiting EPT (0%) and states without a medical board policy statement (1.1%; *P* < 0.01). Similar results were found for nonmedical board policy statements. In states with nonmedical board policy statements permitting EPT, patients with gonorrhea received EPT at a significantly higher rate (24.4%) than in states with nonmedical board policy statements prohibiting EPT (3.8%) and states without a nonmedical board policy statement (1.0%; *P* < 0.1). Washington implemented an extensive statewide effort to increase EPT uptake among providers; therefore, we also examined policy variables excluding this site. The significant differences remained (*P* < 0.01), but the percentage who received EPT dropped to 4.5% where state medical and nonmedical boards had statements permitting EPT.

Multiple Logistic Regression Models

In adjusted analyses, patients with gonorrhea in states that have an EPT law and where EPT is considered permissible (adjusted odds ratio [AOR], 23.2 [95% confidence interval [CI], 6.0–89.8]) and states that do not have an EPT law but where EPT is considered permissible (AOR, 7.3 [95% CI, 1.7–30.7]) were more likely to have received EPT than patients with gonorrhea in states without a law and where EPT is potentially allowable (Table 1). Of the demographic variables included in the model, sex of sex partners was the only variable that remained statistically significant in adjusted analysis. MSW were less likely to receive EPT than women (AOR, 0.4 [95% CI, 0.2–0.8]), as were MSM (AOR, 0.3 [95% CI, 0.2–0.70]). Race/ethnicity and having a recently incarcerated partner (past 12 months) were not significant in adjusted analyses.

Finally, we conducted 2 additional analyses to determine if findings were the same when separately excluding 1) MSM and 2) Washington (data not shown in tables). When excluding MSM, the findings for the law-legal status variable, sex of sex partners, and having an incarcerated partner in the past 12 months were similar to results from the overall model; however, we found one difference in that non-Hispanic whites (AOR, 2.1 [95% CI, 1.1–4.1]) were significantly more likely than non-Hispanic blacks to have received EPT. When excluding

Washington, the only finding that was not similar to the overall model was that patients with gonorrhea in states that do not have an EPT law but where EPT is considered permissible (AOR, 1.9; 95% CI, 0.5–7.6]) did not differ from patients in sites without a law and where EPT is considered potentially allowable.

DISCUSSION

This study suggests that laws and policies authorizing EPT are associated with higher reports of receipt of EPT among patients with gonorrhea, when adjusting for patient and provider variables associated with EPT. Although this is the first study to evaluate the relationship between laws and EPT by comparing uptake across states of varying legal environments, our findings are consistent with evaluations of EPT uptake within jurisdictions that have laws authorizing EPT.¹² Potential explanations include the possibility that laws authorizing EPT may diminish provider concern for legal liability, as such laws explicitly make the practice of EPT legal within a jurisdiction. Uptake is also

TABLE 2. Receipt of EPT Among Interviewed Patients With Gonorrhea by Board Opinions: SSuN Sites Without Law Authorizing EPT for Gonorrhea

Policy Variables	Bivariate Analyses		
	Unweighted, n	Weighted, % (SE)	P
All 7 sites (n = 1363)			
State medical board opinion*			<0.01
Yes, prohibits	0	0	
Yes, permits	448	24.4 (10.1)†	
No	915	1.1 (0.4)†	
Other nonmedical board opinion*			<0.01
Yes, prohibits	115	3.8 (0.8)	
Yes, permits	448	24.4 (10.1)†	
No	800	1.0% (0.4)†	
6 sites without a statewide effort to promote EPT (n = 1124)			
State medical board opinion*			<0.01
Yes, prohibits	0	0	
Yes, permits	209	4.5 (0.5)	
No	915	1.1 (0.4)†	
Other nonmedical board opinion*			<0.01
Yes, prohibits	115	3.8 (0.8)	
Yes, permits	209	4.5 (0.5)	
No	800	1.0 (0.4)†	

*Board rulings defined as “prohibit” did not refer directly to EPT. †Estimate is unstable: relative standard error is greater than 30%.

higher in jurisdictions where EPT is deemed permissible versus those in which it is potentially allowable, notwithstanding the existence of an EPT law. However, in adjusted analyses, these findings were only observed when the site with an intensive statewide effort to promote the use of EPT (Washington) was included.

This study found that having a law or a regulation authorizing EPT was associated with higher receipt of EPT. However, in states where such laws or regulations do not exist, our findings suggest that professional licensure board policy statements are related to an increase in the receipt of EPT because the receipt of EPT was significantly higher in states with policy statements endorsing EPT, even when excluding Washington. It should be noted, however, that board policy statements do not carry the force of law as do statutes and regulations; policy statements are, nevertheless, highly presumptive of boards' priorities in terms of regulating health care professionals.

It is worth noting that receipt of EPT was low overall, with fewer than 1 in 10 patients with gonorrhea reporting that they received it. Although receipt of EPT for gonorrhea was higher within jurisdictions with laws authorizing EPT for gonorrhea, it was still relatively low in these areas. Thus, although laws may alleviate provider concerns with dispensing medication without a physical examination, other possible barriers to the use of EPT may remain. Among providers, awareness of EPT and reimbursement issues may inhibit EPT use even in supportive legal environments. Furthermore, technological advancements such as electronic health records may optimize the practice of EPT.¹⁵ Finally, it is possible that uptake of new strategies may take several years; therefore, future research should examine the time since a law took effect and health department and other organizations' efforts to increase the use of EPT.

There are some limitations to our analysis. First, our findings may not be generalizable to patients with gonorrhea across the United States, given that only 12 sites participated in SSuN (accounting for approximately 20% of US gonorrhea cases) and the response rate was low (39%). In addition, the number of sites produced limited legal environment variation. The second limitation is that this study analyzes the receipt of EPT among patients with gonorrhea, yet it has been suggested that EPT is more commonly provided to patients with chlamydia. This limitation was caused by the lack of available data on the receipt of EPT for chlamydia; future studies should investigate this issue as such data become available. In addition, given increasing antimicrobial resistance, in 2012, the CDC amended its guidance concerning EPT for gonorrhea stating "if a heterosexual partner of a patient cannot be linked to evaluation and treatment in a timely fashion, then expedited partner therapy should be considered, using oral combination antimicrobial therapy for gonorrhea...."¹⁷ Thus, the receipt of EPT for gonorrhea may have changed since the time of data collection, and concerns regarding susceptibility to oral cephalosporins may limit the practice of EPT for gonorrhea moving forward. Third, this study is not a randomized controlled trial; causality cannot be inferred from our results. Lastly, it is possible that states with providers more receptive to EPT are more likely to pass a law. Thus, the receipt of EPT itself could cause a legal environment more amenable to EPT, rather than the legal environment facilitating its practice. In addition, it is possible that health departments may more actively promote the use of EPT in states that pass laws.

The results of this analysis show that, within our sample, individuals with gonorrhea in jurisdictions that have an EPT law and, to a lesser degree, jurisdictions where EPT is considered legally permissible are significantly more likely to receive EPT

as a treatment option. Similarly, in those jurisdictions without an EPT law, EPT was practiced at a significantly higher rate in jurisdictions with a medical or nonmedical board that supports its practice. For jurisdictions wanting to increase the receipt of EPT, this study suggests that laws and policies may be effective options for doing so.

REFERENCES

1. Golden MR, Whittington WL, Handsfield HH, et al. Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydial infection. *N Engl J Med* 2005; 352:676–685.
2. Schillinger JA, Kissinger P, Calvet H, et al. Patient-delivered partner treatment with azithromycin to prevent repeated *Chlamydia trachomatis* infection among women: A randomized, controlled trial. *Sex Transm Dis* 2003; 30:49–56.
3. Trelle S, Shang A, Nartey L, et al. Improved effectiveness of partner notification for patients with sexually transmitted infections: Systematic review. *BMJ* 2007; 334:354.
4. Kissinger P, Mohammed H, Richardson-Alston G, et al. Patient-delivered partner treatment for male urethritis: A randomized, controlled trial. *Clin Infect Dis* 2005; 41:623–629.
5. Centers for Disease Control & Prevention (CDC). Sexually Transmitted Disease Surveillance 2010. Atlanta: U.S. Department of Health and Human Services; 2011. Available at: <http://www.cdc.gov/std/treatment/2010/toc.htm>. Accessed April 14, 2012.
6. Schneider JF. Expedited partner therapy (patient-delivered partner therapy): An update. 2006. Available at: <http://www.ama-assn.org/resources/doc/csaph/a06csaph7-fulltext.pdf>. Accessed April 13, 2012.
7. Expedited Partner Therapy in the Management of Gonorrhea and Chlamydia by Obstetrician-Gynecologists. September 2011. Available at: <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Adolescent%20Health%20Care/co506.aspx?dmc=1&ts=20111207T1406092727>. Accessed April 13, 2012.
8. American Bar Association Recommendation 116A. August 12, 2008. Available at: <http://www.abanet.org/leadership/2008/annual/adopted/OneHundredSixteenA.doc>. Accessed April 14, 2012.
9. Handsfield HH, Hogben M, Schillinger JA, et al. Expedited partner therapy in the management of sexually transmitted diseases. 2006. Available at: <http://www.cdc.gov/std/treatment/EPTFinalReport2006.pdf>. Accessed April 16, 2012.
10. Hodge JG, Pulver A, Hogben M, et al. Expedited partner therapy for sexually transmitted diseases: Assessing the legal environment. *Am J Public Health* 2008; 98:238–243.
11. Legal Status of Expedited Partner Therapy. February 9, 2012. Available at: <http://www.cdc.gov/std/ept/legal/default.htm>. Accessed April 13, 2012.
12. Jotblad S, Park IU, Bauer HM, et al. Patient-delivered partner therapy for chlamydial infections: Practices, attitudes, and knowledge of California family planning providers. *Sex Transm Dis* 2012; 39:122–127.
13. Yu Y, Frasure-Williams JA, Dunne EF, et al. Chlamydia partner services for females in California family planning clinics. *Sex Transm Dis* 2011; 38:913–918.
14. Gift TL, Kissinger P, Mohammed H, et al. The cost and cost-effectiveness of expedited partner therapy compared with standard partner referral for the treatment of chlamydia or gonorrhea. *Sex Transm Dis* 2011; 38:1067–1073.
15. Mickiewicz T, Al-Tayyib A, Thrun M, et al. Implementation and effectiveness of an expedited partner therapy program in an urban clinic. *Sex Transm Dis* 2012; 39:923–929.
16. Taylor MM, Collier MG, Winscott MM, et al. Retention to prescribe: Utilization of expedited partner therapy among obstetric providers in Arizona. *Int J STD AIDS* 2011; 22:449–452.
17. Centers for Disease Control & Prevention (CDC). Update to CDC's sexually transmitted disease treatment guidelines, 2010: Oral cephalosporins no longer a recommended treatment for gonococcal infections. Atlanta: U.S. Department of Health and Human Services; 2012. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6131a3.htm?s_cid=mm6131a3_w. Accessed September 17, 2012.