DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)

DATE: October XX, 2010

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SUBJECT: EPI-AID 2010-064: Assessment of opportunities for enhanced gonorrhea and chlamydia control – Alaska, 2010

TO: Douglas H. Hamilton, MD, PhD, Director, EIS Program, Division of Applied Sciences (proposed) Scientific Education and Professional Development Program Office, Office of Surveillance, Epidemiology and Laboratory Services, Centers for Disease Control and Prevention

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BACKGROUND

In August 2009, Alaska state health officials reported an increase in gonorrhea infection in the Southwest region of the state and in March 2010 reported that the gonorrhea infection rate was increasing statewide. The 2009 case rate of 145 cases per 100,000 persons was a 71% increase from the 2008 rate of 85 cases per 100,000 persons, the largest single year increase in Alaska since the 1970s. From January 2008 to June 2009, gonorrhea testing completed in the Alaska State Public Health Laboratory did not increase, but the proportion of specimens which tested positive increased by 1.3% per month. A review of sexually transmitted disease (STD) control operations identified difficulties in treating sex partners, particularly for patients in remote areas. Additionally, Alaska has had the first or second highest chlamydia case rate in the United States each year since 2000 and rates have increased nearly every year since 1996. Co-infection is also common; in 2009, 296 (30%) reported gonorrhea cases occurred in persons who were co-infected with chlamydia.

Little is known about the knowledge, attitudes, and practices regarding expedited partner therapy (EPT) in Alaska. EPT is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partners. While existing state law does not explicitly prohibit EPT in Alaska, the State Medical Board has proposed regulation that will support its use. The proposed regulatory change states that prescribing EPT for sexually transmitted diseases is not considered unprofessional conduct.

In May 2010, the Alaska Department of Health & Social Services Section of Epidemiology (ADHSS SOE) requested assistance from the Centers for Disease Control and Prevention (CDC) in identifying opportunities for enhanced partner services through EPT. On June 3, 2010, an EIS officer from the Division of STD Prevention (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention) traveled to Alaska and was joined by an EIS officer from the Arctic Investigations Program (National Center for Emerging and Zoonotic Infectious Diseases) to assist the state in this investigation.

The primary objectives of this investigation were to:

1. Determine knowledge, attitudes, and practices of expedited partner therapy for gonorrhea and chlamydia control among policy makers, healthcare providers, patients, and other key stakeholders.

2. Develop a plan for implementing and evaluating expedited partner therapy as a gonorrhea and chlamydia control effort.

METHODS

The investigation consisted of five activities.

To determine knowledge, attitudes, beliefs, practices about expedited partner therapy (EPT) and barriers to case treatment and partner notification, we conducted

1. An online statewide survey of healthcare providers;

2. In-person or phone semi-structured interviews with key stakeholders at the state level and at the community level in purposefully sampled areas based on STD morbidity;

3. A self-administered survey of patients receiving STD services or at-risk for STDs in purposefully sampled areas based on STD morbidity; and

4. In-person or phone semi-structured interviews with patients in two purposefully sampled areas based on STD morbidity.

To develop a plan for implementing and evaluating EPT as a gonorrhea and chlamydia control effort, we conducted

5. Meetings with key personnel at the Alaska Department of Health & Social Services Section of Epidemiology (ADHSS SOE) and other key stakeholders.

1. Online statewide survey of healthcare providers

Survey development

We developed a 19 question online survey based on existing EPT and partner notification surveys with input from content experts at CDC and the ADHSS SOE (Attachment 2.1). Local service providers reviewed the survey for cultural competency. The survey was programmed into surveymonkey.com and administered online (www.surveymonkey.com/s/ProviderEPT). A hard copy of the survey was available in the event the online survey was not accessible.

Target population

Healthcare providers in Alaska who care for patients with STDs, including physicians, nurse practitioners, nurses and community health aide/practitioners.

Data collection

The link to the online survey was distributed to healthcare providers across the state via

- Pre-existing listservs of healthcare providers
  - Alaska Nurses Association membership list
  - Public health nursing email list
  - ADHSS SOE *EPI Bulletin* with a specific recommendation that all providers take the survey (Available online at: http://www.epi.alaska.gov/bulletins/docs/b2010_15.pdf)
- Email or phone contact with healthcare facilities with frequent STD reporting to the ADHSS SOE with a targeted request for physicians to complete the survey

The survey was available online for 31 days from Friday, June 11th to Monday, July 12th.

Data analysis

Survey results were outputted from surveymonkey.com into SAS. The dataset was limited to respondents who identified as healthcare providers in Alaska. Descriptive statistics of responses were calculated using SAS v9.13. Responses to open ended questions were reviewed by the two CDC EIS officers and themes identified using content analysis.

2. In-person or phone semi-structured interviews with key stakeholders

Survey development

We developed a 4 question semi-structured interview guide based on input from content experts at CDC and the ADHSS SOE. (Attachment 2.2) Local service providers reviewed the interview guide for cultural competency.

Target population

Stakeholders in STD prevention and control at the state level, including policy makers, administrators and professional licensing board members.

Stakeholders at the community level (e.g. healthcare providers, clinic managers) in purposefully sampled areas based on gonorrhea and chlamydia morbidity:

- Concentrated on areas with highest rates (Anchorage/Mat Su and Southwest) using convenience sample of providers at public, private, tribal and non-profit venues in each region
- Limited coverage in remaining 4 areas (Southeast, Gulf Coast, Northern, Interior) using a convenience sample of providers in tribal health clinics and public health centers

Stakeholders were identified by ADHSS SOE staff with additional key stakeholders identified through local partners and interviews.

Data collection
Participants were contacted by phone and asked to participate in person or by phone. In some cases, a local contact (e.g. hospital medical director, community health aide/practitioner assistant program director) facilitated and/or scheduled interviews with participants. Interviews were conducted by CDC or ADHSS SOE staff. Interviewers took notes, but did not audio record the interviews. Responses were usually summarized rather than written verbatim. Some interviews were conducted in a group setting to accommodate time constraints. Interviews were conducted between June 4th and July 12th. CDC and ADHSS SOE staff traveled to the Southwest region to conduct in-person interviews with key stakeholders in Bethel from June 14th – 16th.

Data analysis
Interview notes were transcribed and were reviewed by the two CDC EIS officers. Themes were identified using content analysis.

3. <u>Self-administered survey of patients receiving STD services or at-risk for STDs</u>

Survey development
We developed an 18 question survey based on existing EPT and partner notification surveys with input from content experts at State and the ADHSS SOE. (Attachment 2.3) Local service providers reviewed the interview guide for cultural competency. A paper copy of the survey was formatted to be self-administrated, anonymous and fit on two pages. Additionally, the survey was programmed into surveymonkey.com for online data collection and data entry (www.surveymonkey.com/s/PatientEPT).

Target population
Patients being evaluated for STDs or at risk for STD in purposefully sampled areas based on gonorrhea and chlamydia morbidity

- Concentrated on areas with highest rates (Anchorage/Mat Su and Southwest) using convenience sample of venues at public, private, tribal and non-profit venues in each region
- Limited coverage in remaining 4 areas (Southeast, Gulf Coast, Northern, Interior) using a convenience sample of venues in infertility prevention project clinics and public health centers

Additionally, the link to the online version of the survey was distributed to all healthcare providers across the state via ADHSS SOE *EPI Bulletin* with a specific recommendation that all providers ask their patients to take the survey.

Data collection
Participating clinics/venues were given an electronic version of the survey or hard copies. Clinics/venues distributed survey to participants for self-administration. Clinics/venues collected completed surveys, stored them in a secure place and mailed/delivered them to the ADHSS SOE at the end of the data collection

period. Surveys were distributed to clinics/venues beginning June 14th (varying start dates) and data collection continued until July 12th (varying stop dates). Most clinics/venues assisted in data collection for two weeks.

Data entry and analysis
Hard copy surveys were data entered in surveymonkey.com. The complete dataset was outputted from surveymonkey.com into SAS. Descriptive statistics of responses were calculated using SAS v9.13. Responses to an open ended question were reviewed by the two CDC EIS officers and themes identified using content analysis.

4. <u>In-person or phone semi-structured interviews with patients in two purposefully sampled areas</u>
Survey development
We developed a 5 question semi-structured interview guide based on input from content experts at CDC and the ADHSS SOE. (Attachment 2.4) Local service providers reviewed the interview guide for cultural competency.

Target population
Patients diagnosed with gonorrhea or chlamydia or at risk for STDs in a convenience sample of clinics/venues in two purposefully sample areas based on STD morbidity (Anchorage/Mat Su and Southwest).

Data collection
Participants were identified by a local contact (e.g. disease intervention specialist, nurse) who obtained permission from the participant to be interviewed by a CDC or ADHSS SOE staff. Interviews were completed in person or by phone. Interviews completed in person were conducted in a confidential setting (e.g. a clinic exam room). Participants were provided a brief summary of the investigation prior to the interview and told that all information would be kept confidential. Interviewers took notes, but did not audio record the interviews. Responses were usually summarized rather than written verbatim. One group interview was held in a local youth correctional facility. Interviews were conducted between June 11th and June 30th. CDC and ADHSS SOE staff traveled to the Southwest region to conduct in-person interviews with patients in Bethel from June 14th – 16th.

Data analysis
Interview notes were transcribed and were reviewed by the two CDC EIS officers. Themes were identified using content analysis.

5. <u>Meeting with key personnel at the ADHSS SOE and other key stakeholders</u>
We conducted interviews with ADHSS SOE STD/HIV program staff and other key stakeholders to
- Identify existing infrastructure for partner notification/treatment monitoring
- Identify possible infrastructure improvements for partner notification/treatment monitoring
- Identify resources for EPT implementation
- Develop process measures for EPT implementation
- Develop outcome measures for EPT implementation

Interviews were conducted from June 4th to July 2nd.

Non-research determination

Because this evaluation is part of a public health response to the ongoing gonorrhea and chlamydia epidemics in Alaska, the project was determined to be public health practice by both the CDC (Appendix 3.1) and Alaska Area (Appendix 3.2) institutional review boards.

RESULTS

Summary of key findings

EPT practices and attitudes: healthcare providers and other key stakeholders

- 45% (53/119) of healthcare providers use EPT with 12% (14/119) using EPT more than half the time.
- 88% (105/120) of healthcare providers thought EPT would prevent the spread of STDs in Alaska although risk of allergies/adverse reactions was a concern.
- 88% (105/120) of healthcare providers said they would be willing to use EPT and 67% (80/120) said they would use it "usually" or "always" if there were a state recommendation.
- 53% (64/120) of healthcare providers said giving antibiotics would be the most effective EPT method to ensure partners are treated.
- In qualitative interviews and open-ended survey questions, key stakeholders and providers reported that EPT would be useful as a "tool in the toolbox", but may result in missed opportunities such as education, screening for other STDs and extended partner notification.

EPT practices and attitudes: patients

- 62% (202/325) of patients would be willing to use EPT for all of their partners and 93% (301/325) would be willing to use EPT for at least one of their partners.
- 87% (283/325) of patients would be willing to take an antibiotic or get a prescription filled if given to them by a sex partner.
- 86% (281/325) of patients said they knew the names of all of their sex partners.
- 25% (77/325) of patients would *not* be willing to give the names of all of their sex partners to their healthcare provider.
- 8% (26/325) of patients reported that they would keep medication for themselves.
- 19% (63/325) of patients reported that they would prefer provider-conducted partner notification for some partners.
- In qualitative interviews and open-ended survey questions, patients reported that going to the clinic is the best way for partners to get treated.

EPT facilitators and barriers: healthcare providers, other key stakeholders and patients

- State and employer recommendations/guidelines, regulations to decrease liability and easy-to-use patient/partner educational materials may facilitate EPT use.
- Many clinics do not stock oral gonorrhea treatment and a formulary change would be required.
- Cost is a primary barrier with many providers unsure how medication would be financed and if a prescription based model was used, how many patients could afford to fill them.
- Not knowing how to find partners was the most common patient-reported barrier to using EPT (27%, 88/325) and was more often reported as a barrier by men compared to women (40%, 34/86 vs. 23%, 50/222).

1. Online statewide survey of providers

Response

One hundred and forty-six respondents completed the online survey of which 137 (94%) self-identified as healthcare providers in Alaska. The non-healthcare provider respondents included administrative or support staff (e.g. office clerks) (n=3), social services (e.g. behavioral health consultant) (n=4) and pharmacists (n=2). While pharmacists are key stakeholders in STD control programs, they were not systematically recruited for participation in the survey and respondents identifying as pharmacists were not included in the analysis.

Characteristics of respondents (Table 1)

The majority of respondents were nurses (49%) or nurse practitioners (28%). Sixteen physicians (12%) and 10 (7%) community health aide/practitioners completed the survey. Respondents were primarily female (85%), white (81%) and had been providing medical care for 19 years on average (range 0.5 years to 45 years). Providers participated from all regions of the state with the majority of respondents reporting living in the Anchorage/Mat-Su region (44%). Over half of the respondents reported living in cities larger than 20,000 people (55%) and 16% of respondents reside in villages of less than 1000 people.

Characteristics of respondents' practice setting (Table 2)

Respondents were split between providing care at Alaska Native hospital/clinics (36%), public hospital/clinics (35%) and private hospital/clinics (26%) which included non-profit clinics and universities. Provider specialties included family practice (23%) and OB/GYNs (14%). The majority of respondents (72%) reported diagnosing at least one STD in an average month, with a quarter reporting that they diagnosis more than 10 STDs in an average month.

Current partner notification and EPT practices (Table 3 & Table 7)

Ninety percent of respondents stated that they "always" report confirmed or suspected cases to public health. Almost 80% of respondents reported that they "always" tell patients to have their partners seek care and 57% "always" collect partner information, however only 23% "always" follow up to see if partners were treated. Only 15% of respondents stated that "most" or "all" of their patients bring their partners in for treatment. About half of respondents (55%) said that at least some patients refuse or are unable to share their partners' names.

Only a few respondents reported "always" providing prescriptions (6%) or medication (1%) for partners, however 39% had given a prescription and 32% had given medication for their patient's partners. Almost half (45%) of respondents had used either form of EPT with 12% reporting using EPT more than half the time.

There were some differences in use of EPT. Respondents in privately-funded settings reported the highest prevalence of EPT use (80%) and respondents in publicly-funded facilities reported the lowest prevalence (11%). Fewer respondents in the Interior region had used EPT (11%), compared to the other six regions (range: 44-60%).

Attitudes and beliefs about EPT (Table 4 & Table 7)

Almost all respondents (88%) agreed that EPT would prevent the spread of STDs in Alaska and that EPT provides better care for patients by preventing re-infection (85%). Sixty percent thought that EPT should be considered the standard of care and a quarter thought that EPT was too dangerous without

knowing the partners allergy/medical history.

A summary score of the four attitude questions was calculated (score range: 4 – 20). When a 75% cut point was made (a score of 16 or higher), 52% of respondents were classified as having a "positive attitude toward EPT". Physicians and physician's assistants had the highest prevalence of a positive attitude toward EPT (81% and 100%, respectively) and nurses and community health aide/practitioners the lowest (37% and 33%, respectively).

EPT intentions (Table 5 & Table 7)

If a state recommendation were issued, respondents said that they were willing to give antibiotics for partners (85%), give prescriptions for partners (79%) or request field delivered partner therapy (90%). Ninety-six percent said they would do one of the forms of EPT and 84% said they would use one of the forms "usually" or "always". After restricting to just patient delivered EPT, 89% said they would be willing to use EPT and 67% said they would use it "usually" or "always". There were few differences in EPT intentions given a state recommendation. Community health aide/practitioners reported the lowest intended use at 67%.

Facilitators and barriers for EPT use (Table 6)

At least one third of respondents reported that providing EPT would require written guidance (42%) or written instructions to give to the patient (38%). Additionally, at least another third of the respondents reported that they would be more likely to provide EPT for the same two reasons listed above plus: free medications (50%), knowing the names of the partners (41%), access to the partners' medical records (37%) and thinking it was the only way the partners would be treated (57%).

In an open-ended question regarding facilitators for EPT use, respondents reiterated the need for clear guidelines from the state and their employers, as well as patient/partner education material for distribution with the medication or prescription. Additionally, respondents stated that legal protection would increase their willingness to provide EPT.

In an open-ended question on barriers to using EPT, respondents listed concerns about liability, potential for partner's adverse/allergic reactions and patient's misuse of medication.

2. <u>In-person or phone semi-structured interviews with key stakeholders</u>

Participants

We conducted 62 individual interviews and 4 group interviews. Ten interviews were conducted with policy makers at the state-level, including representatives from professional licensing boards, tribal health and Alaska Division of Public Health. Fourteen interviews were conducted with community-level administrators, including clinic managers and non-profit directors. Forty-one interviews were conducted with healthcare providers, including physicians, community health aide/practitioners and nurses. As designed, the majority (75%) of the community-level interviews were conducted in two high-morbidity areas (Anchorage/Mat-Su and Southwest).

EPT Practices

Some respondents indicated that they (or staff at their clinic/facility) were already using some form of EPT for partner treatment, particularly in tribal health facilities where providers can check the medical record system for partner allergies. Some clinics use a hierarchical approach to partner management,

where providers encourage the patient to bring their partners in; but if they won't, EPT services are offered. The majority of providers who had used EPT stated that they usually only provide medication or prescription for one partner.

Attitudes to EPT

Respondents often stated "it's a good idea" when asked what they thought of EPT. Some provided specific examples of how EPT might facilitate partner treatment such as providing additional confidentiality for the patient. Respondents described EPT as being a good "tool in the toolbox" and that EPT may work best with specific populations. Among respondents with direct patient care, some stated that they would use EPT based on their judgment or as long as certain policies or guidelines were in place.

Some respondents expressed specific concerns about EPT. Respondents suggested that EPT might increase antimicrobial resistance and that some partners may have allergic or adverse reactions to the medications. Respondents also questioned patient compliance, suggesting that some patients may not give medication/prescription to their partners or would keep the medication for themselves for future use. Others noted that EPT would result in missed opportunities for education and extended partner notification (e.g. reaching partner's partners).

Facilitators and barriers to EPT

Respondents stated that in addition to state recommendations, having clear guidelines and policies would facilitate EPT use. For example, public health nursing staff would need a medical directive to be able to use EPT. Community health aide/practitioners would need EPT in the Community Health Aide Manual to use EPT routinely. Other providers may need guidelines from their practice groups. Additionally, providers stated that regulations to decrease liability, such as support from professional licensing boards and state legislation, would increase their willingness to use EPT.

Regarding implementation, some providers stated that they currently do not stock oral treatment for gonorrhea and that a formulary change would be required. Respondents stated that they would need clear, easy-to-understand patient/partner materials, perhaps in multiple languages, to distribute.

Respondents suggested that more than just guidelines and recommendations are needed to facilitate widespread EPT use. Respondents recommended having "provider champions [of EPT]" and that having direct contact with providers/health facilities would be needed to ensure implementation of the recommendations.

As previously stated, some respondents expressed concern over allergic or adverse reactions and stated not being able to check for partner's allergies as a primary barrier. Respondents also thought that patient compliance would be a barrier, as patients would hoard the medication or attempt to sell it, would refuse to give medication to all partners, or wouldn't be able to give to all of their partners because of anonymous sex partners (sometimes due to alcohol use).

Respondents expressed concern over the logistics of EPT implementation, including how to document EPT in the patient (or partner) chart and how to document partner treatment to the state.

EPT method

Respondents noted that in many areas of Alaska there are not retail pharmacies and a prescription-based model would not work. Additionally, respondents thought that many partners would not fill prescriptions due to the time required to go to the pharmacy, as well as cost of the medication.

However, respondents noted that having a pharmacy based model might alleviate provider concerns about allergic and adverse reactions and would provide more opportunities to document partner treatment.

Respondents suggested that having a patient directly provide antibiotics to their partners was the model that offered the least barriers to patients. However, respondents noted that this model may have the greatest perceived risk of adverse outcomes and does not easily allow for tracking of partner treatment.

Respondents suggested some alternative models of EPT, including mail-order from a state pharmacy and cooperative agreements with pharmacists.

Ways to improve partner notification and treatment

Respondents described a number of ways to improve partner notification and treatment in Alaska independent of EPT. Respondents suggested that collaboration and communication between stakeholders was necessary. For example, one respondent noted that sometimes partners are contacted by multiple providers/agencies due to lack of communication between providers. Respondents in the Southwest region noted that their regional HIV/STD task force, which includes providers from both public health nursing and tribal health, has been successful in improving service delivery, but that more work is needed. Some non-public health providers stated that they wanted a better understanding of how partner notification worked.

Respondents noted a need for more personnel to conduct partner notification, such as a designated STD staff person at specific health facilities or increasing the use of public health nurses to conduct partner services, particularly in remote areas.

Respondents advocated for improved patient education on the need for a 7-10 day abstinence period following treatment. Respondents suggested that offering training to providers on STDs and partner notification techniques would be useful.

Respondents also suggested using alternate forms of partner notification, such as online notification (e.g. inSpot), or using incentives for participation in partner notification.

Other issues in STD prevention

Respondents discussed other issues related to STD prevention in Alaska, including increasing access to STD testing and condoms. Alcohol was described as the “root cause” of many STD infections as intoxication can lead to risky sexual behaviors. Providers stated that many patients don’t take STDs seriously and they are often the “norm”. Many respondents advocated for increasing sex education, particularly in schools and in villages, noting the need for principal and tribal elder support.

3. <u>Self-administered survey of patients receiving STD services or at-risk for STDs</u>

Response

Seventeen clinics and venues collected self-administered surveys from their patients. Sites were concentrated in Anchorage/Mat Su and Southwest and sites in these regions were a convenience sample of public, private, tribal and non-profit venues. Sites in the four other regions were a convenience sample of infertility prevention project clinics and public health centers. Overall, six of the sites were public health centers, seven sites were non-profit or infertility prevention project clinics, three were private clinics, and two were corrections-based. Overall, 325 patients completed the survey. All

sites returned completed surveys, but the number of surveys varied greatly by site with the majority of the surveys coming from one public health center in the Anchorage/Mat Su region.

Characteristics of respondents (Table P1*)*

The majority of respondents were female (68%), white (61%) and from the Anchorage/Mat Su region (61%). Almost half (45%) were aged 20—29 years old. About a third (36%) lived in communities of over 20,000 people and less than 10% lived in communities of less than 1000 people.

Preferences for partner notification and partner treatment strategies (Table P2)

Almost 80% of respondents stated that they would prefer to tell their sex partners themselves if they had an STD. The majority said they would be willing to bring their partners in with them to the clinic or tell them to get tested (54% and 51%, respectively).

Only 27% percent choose EPT from a list of methods they would be willing to do, but when asked later in the survey for which partners they would be willing to do EPT, 62% of patients were willing to use EPT for all of their partners and 94% were willing to use EPT for at least one of their partners.

Eighty-seven percent of patients said that they would fill a prescription or take medication if given to them by a partner.

Perceived outcome of partner treatment strategies and disclosure of sex partner names (Table P3)

About half of respondents said that all of their partners would come with them to the clinic to be tested/treated and almost 70% of respondents reported that all of their partners would take medication if they gave it to them. The majority of respondents (86%) said they knew the names of all of the sex partners. About a quarter of patients stated that they would not be willing to give the names of all of their sex partners to their healthcare provider.

Barriers to EPT (Table P4)

Not knowing how to find partners was the most commonly reported barrier to using EPT (27%). Less than 10% of patients reported that they would keep medication for themselves. A third of respondents stated that there were not any barriers to doing EPT for all of their sex partners.

Differences by age (Table P5 & Table P6)

When data were stratified by age, there were some differences in participants' responses. Compared to respondents under 20 years, respondents over 30 years reported being: more likely to use EPT for all of their partners (70% vs. 56%); more likely to tell the names of "none" of their sex partners to their healthcare provider (21% vs.11%); and less likely to keep medication for themselves (6% vs. 12%).

Differences by gender (Table P5 & Table P6)

When data were stratified by gender, there were some differences in participants' responses. Compared to females, men were: less likely to know the names of all of their sex partners (77% vs. 93%); less likely to give the names of all of their sex partners to their provider (63% vs. 79%); and more likely to report that they didn't know how to find all of their partners as a barrier to EPT (40% vs. 23%).

4. <u>In-person or phone semi-structured interviews with patients</u>

Participants

Individual interviews (n=17) and one group interview (n=9) were conducted with patients in the Anchorage/Mat Su and Southwest regions. Eleven (42%) of the participants were female and 85% identified as non-white. The majority of participants were under 20 years or 20-29 years (46% and 42%, respectively).

Although we attempted to target patients diagnosed with gonorrhea or chlamydia or at risk for STDs some interviews were conducted with patients reporting no sexual risk. Due to logistical challenges in contacting patients, the sample may not be representative of the target population.

Attitudes to EPT

Patients interviewed reported being willing to give a prescription or medication to their partners, but some stated that there were some partners they would prefer to have public health notify. Some participants said that they would be most willing to do EPT for their main partner or a partner that they were planning on having sex with again. A few patients said that they would not be willing to deliver medications to their partners, stating “I’m not a doctor” and that they would be concerned about their partner having an adverse reaction.

Barriers to EPT

Patients noted that some partners may not fill a prescription due to the challenges of getting to a pharmacy or the cost. Patients reported that it might be difficult to do EPT for “one night stands” or “hook-ups”.

Best way for partner treatment

Some participants thought that EPT (giving medication) would be the best way, while others stated that having their partners come into the clinic would be best. Some participants residing in more remote areas of Alaska discussed the challenges of being treated in small communities, particularly when the healthcare provider is “your auntie” or “your girlfriend’s auntie”.

Other issues in STD prevention

When asked what was needed to prevent the spread of STDs in Alaska, participants discussed more condom availability, more education in schools and increased access to testing. Some patients described how alcohol use is common and often leads to risky behaviors. Some patients interviewed had been diagnosed with STDs multiple times.

5. <u>Meeting with key personnel at the Alaska Department of Health & Social Services Section of Epidemiology (ADHSS SOE)</u>

Existing infrastructure for partner notification/treatment monitoring

There is no standardized method to monitor partner notification outcomes for chlamydia and gonorrhea in Alaska. Some clinics and facilities use standardized interview records and mail them into the ADHSS SOE where some are hand entered in STD*MIS and some are stored without data entry. Some clinics and facilities have their own data management system (e.g. the Municipality of Anchorage clinic). Some

clinics and facilities do not use standardized interview records, but have been encouraged by the ADHSS SOE to track their own data.

Possible infrastructure improvements

ADHSS SOE staff stated that they do not have the existing IT infrastructure to meet their morbidity burden. For example, there is no designated IT support for ADHSS SOE. Staff expressed a need for personnel for data entry, management and analysis. They also noted that state restrictions are a barrier as they are currently unable to fill open, funded positions due to hiring constraints.

EPT evaluation strategies

Multiple strategies for evaluation of an EPT program were identified and discussed, with the caveat that it is difficult to consider evaluation when the program details (e.g. EPT method) have not been finalized.

One suggestion was to pilot EPT in a few facilities, targeting those that have standardized data collection infrastructure in place (e.g., Municipality of Anchorage clinic). Process measures could include how many patients were offered and accepted EPT, as well as for how many partners. This measurement would require an additional “disposition code” to be added to the interview record.

Another suggestion was to document community-level measures of EPT use through periodical surveys of healthcare providers, perhaps using the epi-aid findings as a baseline measure.

It was noted that more intensive evaluation efforts, such as contacting partners to document EPT delivery, would require resources outside of the state’s capacity. Collaborative efforts, including partnerships with academic institutions, were also discussed.

Juneau (SEARHC) model

Since 2007, the Southeast Alaska Regional Health Consortium (SEARHC), the tribal health corporation in Juneau has implemented a pharmacy-based EPT model based on collaboration between tribal health and public health nursing. Interviews with staff members from SEARHC and public health nursing in the region, along with ADHSS SOE staff involved in the development of the program were conducted.

Under the SEARHC model, patients testing positive for chlamydia at the tribal health are interviewed or complete referral cards to identify partners. Partners (beneficiaries of tribal healthcare and non-beneficiaries) bring the referral card to the SEARHC pharmacy to receive treatment. Upon arrival at the pharmacy, the partner is sent to a SEARHC laboratory close by and provides a urine sample. The partner is then given treatment at the pharmacy. The partner’s urine sample is tested (either by SEARHC or the public health lab depending on beneficiary status). Both the original patient and partners who tests positive are referred to the public health center for further follow-up, including partner services, education, and verification that the patient was treated. Based on discussion with staff members, the model works well, but is not currently being evaluated. The staff stressed that collaboration between tribal health and public health nursing was one of the keys to its success, as well routine follow-up consultations after implementation to identify and resolve barriers.

DISCUSSION OF FINDINGS

Since 2005, the CDC has recommended that EPT be available to providers as an option for partner management of patients diagnosed with chlamydia or gonorrhea. EPT represents an additional partner management tool to prevent and control STDs and does not replace other strategies such as partner services

when available.[1]

This investigation provides evidence of the knowledge, attitudes and practices of EPT among key stakeholders in Alaska, including healthcare providers and patients. Similar to national and other state or city-based surveys[2-4] about half of healthcare providers in Alaska surveyed reported using EPT. The majority of providers reported believing that EPT would prevent STDs in Alaska and that they would be willing to use EPT if there were state recommendations. Similarly, the majority of patients surveyed reported that they would use EPT to get their partners treated and would accept EPT if offered to them by a partner.

The investigation identified differences in EPT use by both provider type and facility setting. Nurses, community health aides/practitioners and providers in publicly-funded sites reported the lowest prevalence of EPT use. The majority of respondents from public health settings were nurses (85%). Nurses are not able to dispense medications without standing orders and currently there is no medical directive for EPT in public health centers, limiting EPT use. Similarly EPT is not currently part of the Community Health Aide Manual and so community health aide/practitioners are not able to routinely use EPT. The differences in prevalence in these two measures (provider type and setting) likely confound estimated prevalence of EPT use in other variables (e.g. more public health nurses are in clinics which diagnose more than 10 STDs per month).

This investigation also identified perceived barriers and facilitators to EPT use. Many of the identified barriers could be likely overcome by policy and regulation changes, such as creating standing orders. For example, although only 35% of healthcare providers in publicly-funded sites reported a positive attitude toward EPT, 73% reported being willing to use EPT usually or always if there were a state recommendation. This suggests that for providers working under medical directives, having policies and guidelines in place will facilitate use. Additionally, formulary changes to stock oral treatment of gonorrhea would be required in some places in order to use EPT for gonorrhea. Having easy to understand patient and partner education materials was often named as a facilitator to EPT use. Existing materials from other states could be modified and made culturally relevant to Alaskan populations.

When discussing the strengths and weaknesses of different partner notification strategies, including EPT, key stakeholders described an inverse relationship between perceived patient/partner compliance and perceived risks to providers and partners. Although many patients reported that they would prefer to have their partner come in to the clinic with them, only half said that all of their partners would follow-through, in part because it requires partner's effort and resources (e.g. time and money). Partner effort is reduced by using an EPT pharmacy-model (e.g. no clinical exam is required) and is further reduced if the patient is able to give partners medication directly. Reducing barriers may increase the likelihood of partner treatment, or as one participant stated "the more accessible, the more successful".

However, as partner effort decreases, providers' perceived risk increases. When partners come into a clinic for treatment, providers can check for allergies, screen for other STDs, provide other services (e.g. family planning services) and offer counseling. Without a clinical visit, these opportunities are lost and providers may feel they are providing suboptimal care, perhaps at some legal risk. EPT models which are pharmacy-based are "riskier" as the provider does not have contact with the partner, but partners could be screened for allergies by the pharmacist which could be perceived as reducing provider liability and increasing patient safety. EPT models which are medication based may be perceived as the "riskiest" as partners are receiving medication without any interaction with a healthcare provider. Reducing provider's perceived risk may increase the likelihood of EPT use, particularly for those providers not operating under medical directives.

There is no clear "best" EPT delivery system and finding the most effective model is a balance between both what patients/partners are willing to do and what providers are willing to do. Additionally, due to differences in healthcare delivery systems across the state, it may be impractical to identify one specific EPT implementation model. For example, a pharmacy model may work in cities, but is not feasible in rural settings in Alaska. Additionally it may be beneficial for specific clinics or practices to develop internal EPT guidelines. Based on

experiences in Juneau and suggestions from key stakeholders, using “provider champions” and having follow-up meetings/trainings may help facilitate implementation. Educational materials for providers clearly describing scientific evidence for EPT and actual risks (e.g. likelihood of adverse reactions based on other state’s experiences) may decrease implementation barriers.

Evaluation of EPT outside of clinical trial settings is difficult. Primary challenges to evaluating an EPT program in Alaska will be lack of an existing infrastructure to monitor partner notification outcomes. Collaboration with other institutions, such as the University of Alaska-Anchorage Department of Health Sciences, may provide opportunities for evaluation.

Survey respondents and interview participants provided some insight on challenges to STD control in Alaska. Both healthcare providers and patients identified alcohol as a “root cause” of many sexually transmitted infections. Sexual behaviors under the influence of alcohol increase opportunities for disease spread and can hinder partner treatment, even if EPT is available, when sex partners are unable to be identified. Providers’ perceptions that many patients are not concerned about STDs and patient reports of multiple infections suggest that social norms around STDs may influence patient’s sexual risk behaviors. Key stakeholders, including policy makers and patients, advocated for increasing sex education in both schools and villages to prevent STDs. Although this investigation did not systematically examine the impact of sexual behaviors, social norms, and availability of sex education on the chlamydia and gonorrhea epidemics in Alaska, these findings suggest a need to strengthen primary prevention strategies.

This investigation is subject to several limitations. Respondents to both the healthcare provider and patient survey were convenience samples and may not be representative of the target populations. There is no denominator data available for either sample to calculate a response rate. No incentive was offered to healthcare providers to complete the survey and consequently providers with strong opinions about EPT (for or against) may have been more likely to respond. As the healthcare provider survey was distributed via pre-existing listservs, the sample may be biased toward public health workers and nurses. The patient survey was distributed in a sample of clinics, primarily in hub cities, and patients living in more remote areas may be underrepresented. Additionally, the patient survey was completed by patients currently accessing a clinic and may be biased toward a population with greater actual and perceived health care access.

CONCLUSIONS

Based on findings from this investigation, EPT would be an acceptable partner management tool for the prevention and control of gonorrhea and chlamydia in Alaska. Alaska is one of the few program areas in the United States in which the majority of patients diagnosed with chlamydia or gonorrhea are offered provider-based partner services. As the clinical trials of EPT have primarily compared EPT to patient referral (the patient tells partners to be tested/treated) it is unknown how effective EPT will be in Alaska. However, it is also unknown how effective partner services are in Alaska, as collection of partner services data and evaluation of program efforts are inconsistent across the state due to limited and varied resources and infrastructures. EPT may be a more effective partner management tool for specific populations (e.g. patients unwilling or unable participate in timely partner services), for specific geographic areas where partners services are not available, or when program resources may need to be redirected (e.g. during outbreak response or due to budget changes). Monitoring and evaluation of partner services activities can inform where and how EPT may be most useful.

RECOMMENDATIONS

1. Develop state guidance for EPT use in Alaska which is flexible enough to accommodate the multiple healthcare delivery systems across the state;

2. Increase efforts to track and evaluate existing partner notification programs statewide;

3. Promote EPT in areas where partner services are not available or not successful as indicated by monitoring and evaluation data;
4. Consider piloting EPT in settings where information technology and personnel infrastructure is currently in place to monitor partner treatment outcomes and use evaluation data to inform EPT recommendations;
5. Collaborate with partners to provide technical assistance on EPT implementation and evaluation; and
6. Improve understanding of high-risk sexual behaviors and social norms to inform and target primary prevention strategies.

FUTURE PLANS

Analyses of data from this investigation are ongoing. We plan work with Alaska Department of Health & Social Services Section of Epidemiology to write an *EPI Bulletin* on the findings, present findings at the Alaska HIV/STD Task Force Meeting in September and provide technical assistance as needed.

NOTE

This trip report summarizes the field component of our EPI-AID investigation. Because of the preliminary nature of this investigation, future correspondence, *EPI Bulletin* articles, conference presentations or peer-reviewed papers might present results, interpretations, and recommendations that are different from those contained in this document.

References

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TABLE 1. Self-reported demographics of healthcare providers completing online survey on STD partner services and EPT, Alaska 2010

	n	%
*Provider type**		
Community Health Aide/Practitioner	10	7%
Nurse	67	49%
Nurse practitioner	38	28%
Physician	16	12%
Physician's assistant	5	4%
Missing	1	1%
Gender		
Female	116	85%
Male	20	15%
Missing	1	1%
*Race***		
Alaskan Native/American Indian	16	12%
Asian/Pacific Islander	3	2%
Black/African American	5	4%
Hispanic	4	3%
White	120	88%
Missing	4	3%
Race		
Non-white	22	16%
White only	111	81%
Missing	4	3%
	mean (sd)	*range*
Number of years providing healthcare	19 (11)	0.5 - 45
Missing	25	18%
Region of Alaska		
Anchorage/Mat-Su	60	44%
Gulf Coast	5	4%
Interior	19	14%
Northern	14	10%
Southeast	17	12%
Southwest	19	14%
Missing	3	2%
Size of community		
Less than 1000	21	15%
1000 - 5000	13	9%
5001 - 20,000	26	19%
More than 20,000	75	55%
Missing	2	1%

*Write in responses recoded to appropriate categories; **Not exclusive; sd=standard deviation

TABLE 2. Self-reported practice setting characteristics of healthcare providers completing online survey on STD partner services and EPT, Alaska 2010

	n	%
*Clinic or hospital setting**		
AK Native Health Corporation	49	36%
Publicly-funded	48	35%
Privately-funded	36	26%
Other	2	1%
Missing	2	1%
*Provider specialty**		
Emergency Medicine	4	3%
Family Practice	32	23%
Internal Medicine	2	1%
Ob/Gyn	19	14%
Pediatrics	3	2%
No specialty	10	7%
Other (write in)		
Public Health	32	23%
Other	33	24%
Missing	2	1%
# of STDs diagnosed in a month		
None	21	15%
1-10	63	46%
More than 10	35	26%
Don't know	15	11%
Missing	3	2%

STD: Sexually transmitted disease; EPT: Expedited partner therapy
*Write in responses recoded to appropriate categories

TABLE 3. Self-reported partner notification and partner treatment practices for patients with chlamydia or gonorrhea, Alaska 2010

	Never (0%)	Rarely (1-10%)	Sometimes (11-49%)	Usually (50-90%)	Always (91-100%)
	n (%)*	n (%)*	n (%)*	n (%)*	n (%)*
When a patient in your clinic is diagnosed with chlamydia or gonorrhea, how often do you or your office staff…					
Tell the patient to tell their partner(s) to seek care	3 (3%)	5 (4%)	2 (2%)	16 (13%)	93 (78%)
Collect partner information and notify partner(s)	15 (13%)	7 (6%)	10 (8%)	19 (16%)	68 (57%)
Give patient a prescription for their partner(s)	73 (61%)	16 (13%)	17 (14%)	6 (5%)	7 (6%)
Give patient medication for their partner(s)	81 (68%)	20 (17%)	10 (8%)	6 (5%)	1 (1%)
Follow-up with patient to inquire about partner(s) treatment	31 (26%)	20 (17%)	21 (18%)	19 (16%)	27 (23%)
Report confirmed/suspected case to public health	6 (5%)	0 (0%)	1 (1%)	4 (3%)	107 (90%)
	None (0%)	Few (1-10%)	Some (11-49%)	Most (50-90%)	All (91-100%)
	n (%)**	n (%)**	n (%)**	n (%)**	n (%)**
When a patient in your clinic is diagnosed with chlamydia or gonorrhea, what percentage of your patients…					
Are unable or refuse to provide information to you about their partner(s)	7 (6%)	46 (40%)	42 (36%)	17 (15%)	3 (3%)
Bring their partner(s) in to your clinic for treatment	16 (14%)	41 (35%)	42 (36%)	16 (14%)	1 (1%)

**Percents represent distribution among respondents who answered at least one question in this section (n=119). 18 respondents did not answer <u>any</u> questions in this section. Of the 18, all but 1 did not diagnose any STDs in an average month or didn't know.

*Percents represent distribution among respondents who answered at least one question in this section (n=116). 21 respondents did not answer either question in this section. Of the 21 all but four did not diagnose any STDs in an average month or didn't know.

TABLE 4. Healthcare providers attitudes and beliefs about EPT, Alaska 2010

	Strongly disagree	Disagree	Neither agree/ disagree	Agree	Strongly agree
	n (%)*	n (%)*	n (%)*	n (%)*	n (%)*
Expedited partner therapy for chlamydia or gonorrhea…					
would help to prevent the spread of STDs in Alaska	3 (3%)	3 (3%)	9 (8%)	54 (45%)	51 (43%)
helps provide better care for patients by preventing re-infection	4 (3%)	3 (3%)	12 (10%)	51 (43%)	50 (42%)
should be considered the standard of care	8 (7%)	7 (6%)	32 (27%)	34 (28%)	38 (32%)
is too dangerous without knowing the medical/allergy history of the partner(s)	10 (8%)	39 (33%)	38 (32%)	28 (23%)	5 (4%)

EPT: Expedited partner therapy; STD: Sexually transmitted disease
*Percents represent distribution among respondents who answered at least one question in this section (n=120). 17 respondents did not answer any of the questions in this section. Of the 17 all but two did not diagnose any STDs in an average month or didn't know.

TABLE 5. Healthcare providers willingness to use EPT, Alaska 2010

	Never (0%)	Rarely (1-10%)	Sometimes (11-49%)	Usually (50-90%)	Always (91-100%)	Method that would be "most effective"
If there were a statewide recommendation to use expedited partner therapy for partners of patients with chlamydia or gonorrhea, how often would you do each of the following?	n (%)*	n (%)*	n (%)*	n (%)*	n (%)*	n (%)*
I would give a patient medication for their partner(s)	18 (15%)	10 (8%)	25 (21%)	32 (27%)	32 (27%)	64 (53%)
I would give a patient a prescription for their partner(s)	25 (21%)	14 (12%)	21 (18%)	28 (23%)	29 (24%)	12 (10%)
I would request that a public health worker provide medication to the partner(s)	12 (10%)	20 (17%)	21 (18%)	28 (23%)	34 (28%)	27 (23%)
Other**	- -	- -	- -	- -	- -	17 (14%)

EPT: Expedited partner therapy

*Percents represent distribution among respondents who answered at least one question in this section (n=120). 17 respondents did not answer any of the questions in this section. Of the 19 all but two did not diagnose any STDs in an average month or didn't know.

**Write in responses included themed categories of "against EPT" (n=9) or a mixture of strategies (n=4)

TABLE 6. Healthcare providers reported facilitators to EPT use, Alaska, 2010

	Less likely to provide prescription or antibiotics	*Wouldn't affect my decision* to provide prescription or antibiotics	*More likely* to provide prescription or antibiotics	*Necessary* to provide prescription or antibiotics
	n (%)*	n (%)*	n (%)*	n (%)*
How would each of the following affect your decision to give your patient with chlamydia or gonorrhea a prescription or antibiotics for their partner(s)?				
If the state or my employer provided me written guidance on the practice in Alaska	0 (0%)	16 (14%)	52 (44%)	50 (42%)
If the medications are provided for free to my clinic	2 (2%)	24 (20%)	59 (50%)	32 (27%)
If my patient is able and willing tell me the name(s) of their partner(s)	4 (3%)	40 (34%)	48 (41%)	25 (21%)
If I could access the medical records of my patient's partner(s)	2 (2%)	54 (46%)	44 (37%)	17 (14%)
If I thought it was the only way my patient's partner(s) would be treated	2 (2%)	20 (17%)	67 (57%)	29 (25%)
If my patient's insurance would pay for the medications	1 (1%)	86 (73%)	24 (20%)	7 (6%)
If I had written instructions for patients to give to their partner(s) along with the prescription or medication	1 (1%)	18 (15%)	54 (46%)	45 (38%)

EPT: Expedited partner therapy

*Percents represent distribution among respondents who answered at least one question in this section (n=118). 19 respondents did not answer any of the questions in this section. Of the 17 all but one did not diagnose any STDs in an average month or didn't know.

TABLE 7. EPT practices and attitudes by healthcare provider characteristics, Alaska 2010

	Total	Used EPT		Positive attitude toward EPT*		Willing to do EPT** "usually" or "always"	
	N	n	%†	n	%†	n	%†
Total	137	53	45%	62	52%	80	67%
Provider type							
Community Health Aide/Practitioner	10	3	33%	3	33%	2	22%
Nurse	67	9	18%	19	37%	36	71%
Nurse practitioner	38	25	66%	22	58%	26	68%
Physician	16	12	75%	13	81%	12	80%
Physician's assistant	5	3	75%	4	100%	4	100%
Gender							
Female	116	43	42%	49	48%	70	69%
Male	20	10	59%	13	76%	10	63%
Race							
Non-white	22	9	45%	12	57%	11	52%
White	111	42	44%	49	51%	67	71%
Number of years providing healthcare							
<15	41	17	45%	19	50%	27	69%
15-29	40	14	41%	19	86%	22	69%
30+	31	11	41%	12	43%	18	67%
Region of Alaska							
Anchorage/Mat-Su	60	21	44%	27	55%	33	70%
Gulf Coast	5	3	60%	3	60%	4	80%
Interior	19	2	11%	5	28%	11	61%
Northern	14	8	57%	8	57%	10	71%
Southeast	17	9	60%	8	57%	11	73%
Southwest	19	10	56%	11	58%	11	61%
Size of community							
Less than 1000	21	7	37%	9	45%	11	55%
1000 - 5000	13	7	54%	6	55%	8	67%
5001 - 20,000	26	16	70%	15	65%	19	86%
More than 20,000	75	22	35%	31	48%	42	67%
Clinic or hospital setting							
AK Native Health Corporation	49	27	57%	27	56%	29	62%
Publicly-funded	48	5	11%	15	35%	32	73%
Privately-funded	36	20	80%	17	65%	18	75%
# of STDs diagnosed in a month							
None	21	6	40%	7	44%	9	60%
1-10	63	33	53%	36	59%	43	69%
More than 10	35	13	37%	17	49%	26	77%
Don't know	15	0	0%	1	14%	2	33%

STD: Sexually transmitted disease; EPT: Expedited partner therapy; AK: Alaska
*A summary score of 16 or higher on four attitude questions (score range: 4-20); **Provide medication or prescription; †denominator excludes missings

TABLE P1. Self-reported demographics of patients evaluated for STDs or at-risk for STDs, Alaska 2010

	n	%
Gender		
Female	222	68%
Male	86	26%
Missing	17	5%
*Race**		
Alaskan Native/American Indian	53	16%
Asian/Pacific Islander	21	6%
Black/African American	25	8%
Hispanic	11	3%
White	218	67%
Missing	19	6%
Race		
Non-white	107	33%
White (only)	199	61%
Missing	19	6%
Age		
Under 20	103	32%
20-29	147	45%
30-39	34	10%
40 or older	24	7%
Missing	17	5%
Region of Alaska		
Anchorage/Mat-Su	198	61%
Gulf Coast	10	3%
Interior	52	16%
Northern	8	2%
Southeast	20	6%
Southwest	16	5%
Missing	16	5%
Size of community		
Less than 1000	23	7%
1000 - 5000	59	18%
5001 - 20,000	89	27%
More than 20,000	117	36%
Missing	37	11%

STD: Sexually transmitted disease
*Not exclusive

TABLE P2. Preferences for partner notification and partner treatment strategies, Alaska 2010

	n	%
Best way for partners to be told		
Tell them myself	255	78%
Tell some myself/have worker tell some	38	12%
Have worker tell them	25	8%
Other	2	1%
Missing	5	2%
*Would you be willing to…**		
Bring partner(s) with you to clinic	175	54%
Tell partner (s) to get tested/treated	167	51%
Give name(s) to healthcare provider	87	27%
Give partner(s) antibiotics	71	22%
Give partner(s) prescription	53	16%
Other	5	2%
Which partners would you do EPT for?		
All of my partners	202	62%
Only my main partner	78	24%
Only my casual partners	7	2%
Only partners I thought had an STD	14	4%
None of my partners	18	6%
Missing	6	2%
If a sex partner gave you a prescription, would you get it filled?		
Yes	278	86%
No	32	10%
Missing	15	5%
If a sex partner gave you a medicine, would you take it?		
Yes	243	75%
No	63	19%
Missing	19	6%

EPT: Expedited Partner Therapy; STD: Sexually transmitted disease
*Not exclusive

TABLE P3. Patient's perceived outcomes of partner treatment strategies and disclosure of sex partner names, Alaska 2010

	All of them	Some of them	None of them	Missing
	n (%)	n (%)	n (%)	n (%)
Which of your partners would…				
Go with you to the clinic to get tested/treated	170 (52%)	122 (38%)	27 (8%)	6 (2%)
Go to the clinic on their own to get tested/treated	207 (64%)	107 (33%)	6 (2%)	5 (2%)
Fill a prescription you gave them	205 (63%)	103 (32%)	12 (4%)	5 (2%)
Take medication you gave them	218 (67%)	88 (27%)	11 (3%)	8 (2%)
Do you know the names of your sex partners in last 6 months?	281 (86%)	35 (11%)	4 (1%)	5 (2%)
Would you tell your healthcare provider the names of your sex partners?	227 (70%)	35 (11%)	42 (13%)	21 (6%)

TABLE P4. Patient's reported barriers to EPT*, Alaska, 2010

	n	%
Don't know how to find partners	88	27%
Don't want to tell partners	61	19%
Don't want partners to think have STD	46	14%
Partners won't get prescription filled	35	11%
Partners won't take medicine	34	10%
Keep medicine for myself	26	8%
Other (write in)		
Not a doctor/not safe	8	2%
Have only one or no partners	13	4%
Other	15	5%
No reported barriers	102	33%

EPT: Expedited Partner Therapy; STD: Sexually transmitted disease
*Not exclusive

TABLE P5. Preferences for partner notification and partner treatment strategies by patient age and gender, Alaska 2010

	Under 20 years (n=103)		20 - 29 years (n=147)		30 years or older (n=58)		Male (n=86)		Female (n=222)	
	n	%*	n	%*	n	%*	n	%*	n	%*
Best way for partners to be told										
Tell them myself	78	77%	121	83%	43	75%	67	83%	175	80%
Tell some myself/have worker tell some	9	9%	17	12%	9	16%	8	10%	27	12%
Have worker tell them	12	12%	7	5%	5	9%	6	7%	18	8%
*Would you be willing to…***										
Bring partner(s) with you to clinic	52	50%	84	57%	26	45%	38	44%	124	56%
Tell partner (s) to get tested/treated	52	50%	66	45%	36	62%	46	53%	109	49%
Give name(s) to healthcare provider	30	29%	35	24%	17	29%	15	17%	68	31%
Give partner(s) antibiotics	15	15%	35	24%	19	33%	18	21%	51	23%
Give partner(s) prescription	8	8%	23	16%	17	29%	12	14%	37	17%
Which partners would you do EPT for?										
All of my partners	57	56%	95	65%	41	72%	56	67%	137	62%
Only my main partner	27	27%	34	23%	12	21%	13	15%	60	27%
Only my casual partners	5	5%	1	1%	0	0%	2	2%	4	2%
Only partners I thought had an STD	6	6%	7	5%	1	2%	4	5%	10	5%
None of my partners	6	6%	9	6%	3	5%	9	11%	9	4%
Would fill prescription if a sex partner gave it to them	93	90%	129	88%	53	93%	75	88%	200	90%
Would take medication if a sex partner gave it to them	75	74%	119	82%	46	81%	63	76%	177	80%

EPT: Expedited Partner Therapy; STD: Sexually transmitted disease
*Denominator excludes missings; **Not exclusive

TABLE P6. Patient's perceived outcomes of partner treatment strategies and disclosure of sex partner names, by age and gender, Alaska 2010

	Under 20 years (n=103)		20 - 29 years (n=147)		30 years or older (n=58)		Male (n=86)		Female (n=222)	
Which of your partners would…	n	%*	n	%*	n	%*	n	%*	n	%*
Go with you to the clinic to get tested/treated										
All of them	53	52%	84	58%	30	53%	40	47%	127	58%
Some of them	42	41%	52	36%	18	32%	38	45%	74	34%
None of them	7	7%	9	6%	9	16%	7	8%	18	8%
Go to the clinic to get tested/treated										
All of them	64	63%	99	68%	38	67%	59	69%	141	65%
Some of them	37	36%	46	32%	15	26%	25	29%	73	33%
None of them	1	1%	1	1%	4	7%	2	2%	4	2%
Fill a prescription you gave them										
All of them	63	61%	98	68%	37	65%	53	62%	145	66%
Some of them	37	36%	43	30%	15	26%	29	34%	66	30%
None of them	3	3%	4	3%	5	9%	3	4%	9	4%
Take medication you get them										
All of them	67	66%	101	71%	41	72%	56	67%	153	70%
Some of them	31	31%	38	27%	13	23%	24	29%	58	26%
None of them	4	4%	4	3%	3	5%	3	4%	8	4%
Do you know the names of your sex partners in last 6 months										
All of them	89	86%	130	89%	52	90%	66	77%	205	93%
Some of them	13	13%	14	10%	5	9%	17	20%	15	7%
None of them	1	1%	2	1%	1	2%	3	3%	1	1%
Would you tell your healthcare provider the names of your sex partners										
All of them	78	76%	107	75%	11	72%	53	63%	172	79%
Some of them	13	13%	17	12%	19	7%	12	14%	22	10%
None of them	11	11%	4	13%	12	21%	19	23%	23	11%

*Denominator excludes missings

TABLE P7. Patient's reported barriers to EPT by age and gender, Alaska, 2010

	Under 20 years (n=103)		20 - 29 years (n=147)		30 years or older (n=58)		Male (n=86)		Female (n=222)	
	n	%*	n	%*	n	%*	n	%*	n	%*
Don't know how to find partners	28	27%	41	27%	15	26%	34	40%	50	23%
Don't want to tell partners	22	22%	28	19%	11	19%	21	24%	40	18%
Don't want partners to think have STD	14	14%	21	14%	9	16%	11	13%	33	15%
Partners won't get prescription filled	16	16%	12	9%	7	12%	9	11%	26	12%
Partners won't take medicine	16	16%	13	9%	6	10%	7	8%	28	13%
Keep medicine for myself	12	12%	11	8%	3	6%	6	7%	20	9%
Other (write in)										
Not a doctor/not safe	2	2%	4	3%	2	3%	2	2%	6	3%
Have only one or no partners	5	5%	5	3%	3	5%	3	3%	10	5%
Other	4	4%	6	4%	2	3%	2	2%	10	5%
No reported barriers	30	29%	45	31%	19	33%	21	24%	73	33%

EPT: Expedited Partner Therapy; STD: Sexually transmitted disease
*Not exclusive

Attachment 1

Non-research determination materials

1.1 CDC non-research determination
1.2 Alaska Area IRB

REQUEST for Project Determination & Approval - NCHHSTP ADS/ADLS OFFICE

This form should be used to submit proposals to the NCHHSTP ADS/ADLS Office for determination that have not begun and do not require routing to the CDC Human Research Protection Office at this time. Projects eligible for this classification are (1) non-research activities; (2) research that does not involve identifiable human subjects; (3) human subject research in which CDC is not "engaged".

Project Title:
EPI-AID 2010-064: Assessment of Opportunities for Enhanced Gonorrhea and Chlamydia Control

Project Location/Country(ies): Alaska

Project Officer(s): Elizabeth Torrone | Division: DSTDP | Telephone: 404-639-8948

Proposed Project Dates: Start: 6/3/2010 | End: 7/1/2010 | Laboratory Branch Submission: ☐

Please check appropriate category and subcategory:

☒ I. **Activity is not human subjects research.** Primary intent is public health practice or a disease control activity.

- ☒ A. Epidemic or endemic disease control activity; collected data directly relate to disease control (e.g. Epi-AIDs; provide Epi-AID number & documentation of request for assistance, if division policy). Epi-AID # 2010-064
- ☐ B. Routine disease surveillance activity; data used for disease control program or policy purposes.
- ☐ C. Program evaluation activity; data are used primarily for that purpose.
- ☐ D. Post-marketing surveillance of effectiveness or adverse effects of a new regimen, drug, vaccine, or device.
- ☐ E. Laboratory proficiency testing.

☐ II. **Activity is not human subjects research.** Primary intent is public health program activities.

- ☐ A. Public health program activity (e.g., service delivery; health education programs; social marketing campaigns; program monitoring; electronic database construction and/or support; development of patient registries; needs assessments; and demonstration projects intended to assess organizational needs, management, and human resource requirements for implementation).
- ☐ B. Activity is purely administrative (e.g., purchase orders or contracts for services or equipment).

☐ III. **Activity is research but does NOT involve identifiable human subjects.**

- ☐ A. Activity is research involving collection or analysis of data about health facilities or other organizations or units which are not individual persons.
- ☐ B. Activity is research involving data or specimens from deceased persons.
- ☐ C. Activity is research using unlinked or anonymous data or specimens: ALL (1-4) of the following are required:
  - ☐ 1. No contact with human subjects is involved for the proposed activity...**and**...
  - ☐ 2. Data or specimens are/were collected for another purpose...**and**...
  - ☐ 3. No extra data/specimens are/were collected for this purpose...**and**...
  - ☐ 4. Identifying information was: (one of these must be checked)
    - ☐ a. not obtained
    - ☐ b. removed prior to this submission, or prior to CDC receipt, so that data cannot be linked or re-linked with identifiable human subjects
    - ☐ c. protected through an agreement. (*CDC investigators and the holder of the key linking the data to identifiable human subjects enter into an agreement prohibiting the release of the key to the investigators under any circumstances. A copy of the agreement must be attached).

☐ IV. **Activity is research involving human subjects but CDC involvement does not constitute "engagement in human subject research".** **Select only one option below: 'A' indicates the project is funded, 'B' or 'C' indicate there is no current funding**

- ☐ A. This project is funded under a grant/cooperative agreement/contract award mechanism.
  ALL of the following 3 elements are required:
  - ☐ 1. CDC employees or agents will not intervene or interact with living individuals for research purposes.
  - ☐ 2. CDC employees or agents will not obtain individually identifiable private information.
  - ☐ 3. Supported institution must have a Federalwide Assurance (FWA) and project must be reviewed by a registered IRB linked to the supported institution's FWA.

    Supported Institution/Entity Name:
    Supported Institution/Entity FWA # | FWA Expiration Date (mm/dd/yyyy):
    Expiration Date of IRB approval: | *Attach copy of the IRB approval letter.
- ☐ B. CDC staff provide technical support that does not involve possession or analysis of identifiable data or interaction with participants from whom data are being collected (No current CDC funding).
- ☐ C. CDC staff are involved only in manuscript writing for a project that has closed. For the project, CDC staff did not interact with participants and were not involved with data collection (No current CDC funding).

Approval initials & printed name: Tom Peterman 5/28/10 6/8/10

Branch Chief Date ADS/ADLS or Division Director Date

Division Notes/Comments:

Project Title: EPI-AID 2010-064: Assessment of Opportunities for Enhanced Gonorrhea and Chlamydia Control

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NCHHSTP ADS/ADLS Review Date received in NCHHSTP ADS /ADLS office: June 1 2010

☑ Concur, project does not require human subject research review beyond NCHHSTP at this time

☐ Project constitutes human subject research that must be routed to CDC HRPO

Comments/Rationale for Determination:

Attention to all relevant policies, procedures and Regulations is important for participants and project integrity

Signed: Salaam Semaan, MPH. DrPH June 9. 2010

Name Date

Associate (or Acting or Deputy Associate) Director for Science, NCHHSTP

OR

Associate Director for Laboratory Science, NCHHSTP

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Alaska Area Institutional Review Board

4315 Diplomacy Drive - RMCC
Anchorage, AK 99508
Phone: (907) 729-3924

DATE:	June 22, 2010
TO:	Joe McLaughlin, MD, MPH State of Alaska Epidemiology, 3601 C Street, Suite 540, Anchorage, Alaska 99503
FROM:	Alaska Area Institutional Review Board (IHS IRB #2)
STUDY TITLE:	Assessment Opportunites for Enhanced Gonorrhea and Chlamydia Control-Alaska, 2010
IRB REFERENCE #:	2010-06-020
SUBMISSION TYPE:	New Project
ACTION:	DETERMINATION OF Public Health Activity
DECISION DATE:	June 3, 2010

Dear Dr. McLaughlin:

Thank you for your submission of New Project materials for project titled: Assessment Opportunities for Enhanced Gonorrhea and Chlamydia Control- Alaska, 2010. The chairman of the Alaska Area Institutional Review Board (IHS IRB #2) has determined that this project falls well within the parameter of a public health activitiy and does not meet the definition of human subject research under the purview of the IRB according to federal regulations.

We will put a copy of this correspondence on file in our office.

If you have further questions for the Alaska Area IRB you may contact me at tjpowell@anmc.org or call (907) 729-3924.

Sincerely,

Terry J. M. Powell
Alaska Area Institutional Review Board
IRB Administrator
4315 Diplomacy Drive RMCC
Anchorage, Alaska 99508

Attachment 2

OMB Clearance form

Emergency Epidemic Investigations

1. EPI AID No.:	EPI-AID 2010-064
2. Title of Investigation:	Assessment of opportunities for enhanced gonorrhea and chlamydia control – Alaska, 2010
3. Used for the following purpose:	To determine knowledge, attitudes, and practices of expedited partner therapy for gonorrhea and chlamydia control among policy makers, health care providers, patients, and other key stakeholders and to develop a plan for implementing and evaluating expedited partner therapy as a gonorrhea and chlamydia control effort.
4. Date of Investigation:	Beginning: 6/2/2010 End: 7/12/2010

Complete this section for each instrument used during the investigation

Health care provider survey

Data Collection Method

- ☐ Personal Interview
- ☐ Telephone
- ☐ Mail
- ✓ Other (please specify): online survey

A. Description of Respondents: (i.e., individuals, households, physicians, state and local government, etc.)	Health care providers in Alaska
B. Estimated Number of Respondents:	137
C. No. of responses per respondent (i.e., one time only, once a week for 2 weeks).	1
D. Burden per response (i.e. time to complete the data collection instrument)	10 min
Total Annual Burden (multiply B X C X D):	1370 minutes

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11 Atlanta, Georgia 30333; ATTN: PRA (0920-0008)

Key stakeholder interview

Data Collection Method	✓ Personal Interview ☐ Telephone ☐ Mail ☐ Other (please specify):
A. Description of Respondents: (i.e., individuals, households, physicians, state and local government, etc.)	Key stakeholders in STD prevention and control in Alaska
B. Estimated Number of Respondents:	70
C. No. of responses per respondent (i.e., one time only, once a week for 2 weeks).	1
D. Burden per response (i.e. time to complete the data collection instrument)	15 min
Total Annual Burden (multiply B X C X D):	1050 minutes

Patient survey

Data Collection Method	☐ Personal Interview ☐ Telephone ☐ Mail ✓ Other (please specify): self-administered survey
A. Description of Respondents: (i.e., individuals, households, physicians, state and local government, etc.)	Patients being evaluated for STDs or at-risk for STDs
B. Estimated Number of Respondents:	325
C. No. of responses per respondent (i.e., one time only, once a week for 2 weeks).	1
D. Burden per response (i.e. time to complete the data collection instrument)	10 min
Total Annual Burden (multiply B X C X D):	3250 minutes

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11 Atlanta, Georgia 30333; ATTN: PRA (0920-0008)

Patient interview

Data Collection Method	✓ Personal Interview ☐ Telephone ☐ Mail ☐ Other (please specify):
A. Description of Respondents: (i.e., individuals, households, physicians, state and local government, etc.)	Patients being evaluated for STDs or at-risk for STDs
B. Estimated Number of Respondents:	20
C. No. of responses per respondent (i.e., one time only, once a week for 2 weeks).	1
D. Burden per response (i.e. time to complete the data collection instrument)	10 min
Total Annual Burden (multiply B X C X D):	200 minutes

Project Officer:	Name: Elizabeth Torrone
	Title: EIS Officer
	CIO: OID/NCHHSTP/DSTDP/ESB
	Phone: 404-639-8948

Return completed form and blank questionnaire with trip report to, MS-92

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11 Atlanta, Georgia 30333; ATTN: PRA (0920-0008)

Attachment 3
Data collection instruments

3.1 Healthcare provider survey
3.2 Key stakeholder interview guide
3.3 Patient survey
3.4 Patient interview guide

3.1 Healthcare provider survey

Dear colleague-

In 2009, there was a 69% increase in reported cases of gonorrhea in Alaska, the greatest single-year increase in reported gonorrhea infection since the 1970s. Since 2000, Alaska has had the first or second highest chlamydia rate in the United States. The Alaska Section of Epidemiology's HIV/STD Program is working collaboratively with federal, state, tribal, and local health partners to help control these diseases.

As part of this effort, we are conducting this survey to better understand the knowledge, attitudes, practices and barriers regarding the use of expedited partner therapy among Alaska healthcare providers. Findings from this survey will be used in part to guide the development of future STD prevention interventions. **Your input is crucial to help improve the health of our communities.**

Your answers to this survey will not be linked to your name or any other identifying information. If you have any questions concerning the survey, please contact Susan Jones, Alaska HIV/STD Program Manager, at 269-8061 or susan.jones@alaska.gov

This survey should take you **less than 15 minutes** to complete.

Thank you,

Joe McLaughlin, MD, MPH
State Epidemiologist and Chief,
Section of Epidemiology
Alaska Division of Public Health

1. What is your current position/role in your clinic? [choose one]
   - ☐ Community Health Aide/Practitioner
   - ☐ Nurse
   - ☐ Nurse practitioner
   - ☐ Physician
   - ☐ Physician's assistant
   - ☐ Other: _____
   - ☐ Prefer not to answer

2. What is your primary specialty? [choose one]
   - ☐ Emergency Medicine
   - ☐ Family Practice
   - ☐ Internal Medicine
   - ☐ Ob/Gyn
   - ☐ Pediatrics
   - ☐ No specialty
   - ☐ Other: _____
   - ☐ Prefer not to answer

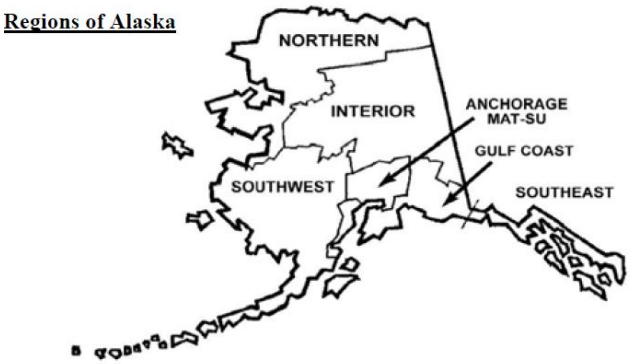
3. What best describes your practice setting? [choose one]
   - ☐ AK Native Health Corporation hospital or village clinic
   - ☐ Publicly-funded clinic/hospital
   - ☐ Privately-funded clinic/hospital
   - ☐ Other: _____
   - ☐ Prefer not to answer

4. Which of the following best describes the size of the community where you work? [choose one]
   - ☐ Less than 1000 people
   - ☐ 1000–5000 people
   - ☐ 5001–20,000 people
   - ☐ More than 20,000 people
   - ☐ Prefer not to answer

5. In an average month, how many patients do you diagnose with an STD? [choose one]
   - ☐ None
   - ☐ 1-10
   - ☐ More than 10
   - ☐ Don't know
   - ☐ Prefer not to answer

6. How many years have you been providing healthcare? [numerical answer]
   Years: ____
   ☐ Prefer not to answer

7. In what region do you live? [choose one]
   ☐ Anchorage/Mat-Su
   ☐ Southwest
   ☐ Southeast
   ☐ Interior
   ☐ Gulf Coast
   ☐ Northern
   ☐ Other:_____



8. What is your gender? [choose one]
   ☐ Male
   ☐ Female
   ☐ Prefer not to answer

9. What is your race? [check all that apply]
   ☐ Alaskan Native/American Indian
   ☐ Asian/Pacific Islander
   ☐ Black or African American
   ☐ Hispanic
   ☐ White
   ☐ Other: _____
   ☐ Prefer not to answer

10. When you diagnose a patient with chlamydia or gonorrhea, how often do you or your office staff do each of the following:

	Never (0%)	Rarely (1-10%)	Sometimes (11-49%)	Usually (50-90%)	Always (91-100%)	Prefer not to answer
Instruct the patient to tell his/her partner(s) to seek care for diagnosis and treatment						
Collect partner information and contact partner(s) for treatment						
Give the patient prescription(s) to bring to their partner(s)						
Give the patient medication to bring to their partner(s)						
Follow-up with the patient to inquire whether partner(s) were treated						
Report the confirmed or suspected case to public health						

11. What percentage of your patients with chlamydia or gonorrhea:

	None (0%)	A few (1-10%)	Some (11-49%)	Most (50-90%)	Almost all (91-100%)	Prefer not to answer
Are unable or refuse to provide information to you about their partner(s)						
Bring their partner(s) in to your clinic for treatment						

Expedited partner therapy is the practice of treating partners of persons with STDs without medical examination or counseling. Scientific studies have shown that giving patients with chlamydia or gonorrhea a prescription or antibiotics to bring to their sexual partner(s) increases the number of partners treated and reduces the patient's risk of re-infection. The next few questions ask your opinions on **expedited partner therapy**.

12. Below is a list of statements related to **expedited partner therapy**. Please rate how strongly you agree or disagree with each of the following statements.

Expedited partner therapy for chlamydia or gonorrhea…	Strongly disagree	Disagree	Unsure	Agree	Strongly agree	Prefer not to answer
would help to prevent the spread of STDs in Alaska						
helps provide better care for patients by preventing re-infection						
should be considered the standard of care						
is too dangerous without knowing the medical/allergy history of the partner(s)						

13. If there were a statewide recommendation to use **expedited partner therapy** for partners of patients with chlamydia or gonorrhea, how often would you do each of the following?

I would…	Never (0%)	Rarely (1-10%)	Sometimes (11-49%)	Usually (50-90%)	Always (91-100%)	Prefer not to answer
give a patient medication for their partner(s)						
give a patient a prescription for their partner(s)						
request that a public health worker provide medication to the partner(s)						

14. Which type of **expedited partner therapy** do you think would be most effective for making sure that partner(s) of your patients are treated for gonorrhea or chlamydia? [choose one]
    - ☐ I give my patient antibiotics for their partner(s)
    - ☐ I give my patient a prescription for their partner(s)
    - ☐ I request that a public health worker provide medication to the partner(s)
    - ☐ Other method: _____
    - ☐ Prefer not to answer

15. How would each of the following affect your decision to give your patient with chlamydia or gonorrhea a prescription or antibiotics for their partner(s)?

	Less likely to provide prescription or antibiotics	Wouldn't affect my decision	More likely to provide prescription or antibiotics	Necessary to provide prescription or antibiotics	Prefer not to answer
If the state or my employer provided me written guidance on the practice in Alaska					
If the medications are provided for free to my clinic					
If my patient is able and willing tell me the name(s) of their partner(s)					
If I could access the medical records of my patient's partner(s)					
If I thought it was the only way my patient's partner(s) would be treated					
If my patient's insurance would pay for the medications					
If I had written instructions for patients to give to their partner(s) along with the prescription or medication					

Last questions!

16. What do you think would be the biggest barrier(s) to giving patients with chlamydia or gonorrhea prescriptions or antibiotics for their partner(s)? [open ended]

17. What other factors would increase your willingness to provide patients with chlamydia or gonorrhea prescriptions or antibiotics for their partner(s)? [open ended]

18. What other strategies would you consider for partner treatment for chlamydia or gonorrhea? [open ended]

19. Please tell us any comments or feedback you have on this survey. [open ended]

Thank you for your time! We appreciate your input into this important health issue in Alaska.

If you would like to learn more about expedited partner therapy, please visit:
www.cdc.com/std/ept

If you would like to learn more about the recent increases in gonorrhea in Alaska, please see this recent EPI Bulletin:
http://www.epi.alaska.gov/bulletins/docs/b2010_06.pdf

3.2 Key stakeholder interview guide

Provide brief background on interview:

Alaska has the second highest rate of chlamydia in the United States and saw significant increases in reported cases of gonorrhea in the last two years. Studies have shown that providing antibiotics to patients with chlamydia or gonorrhea to give to their partners reduces patient's risk of re-infection. We're trying to learn what people think about this practice and how it might be best implemented here in Alaska.

Questions

1. What do you think about providers giving patients with chlamydia or gonorrhea antibiotics to give to their partners? (probe on efficacy)

   What do you think about providers giving patients a prescription to give to their partners? (probe on efficacy)

   If participant has direct patient contact: How likely it is that you would do give antibiotics or a prescription to your patient to give their partners? What would influence your decision?

2. What do you think are the barriers to implementing a program where providers gave antibiotics or prescriptions to their patients with chlamydia or gonorrhea?

   Probe on policy, cost, legal, and patient-level barriers

   Probe on differences between providing antibiotics/prescriptions

3. What other tools could providers use to improve partner notification/treatment?

4. Is there anything else you'd like to tell us about how to prevent STDs in Alaska?

Your answers will not be linked to your name and we will not share any of your personal details, but we have just a few questions so that we can describe who we interviewed.

Gender [Check one]

- ☐ Male
- ☐ Female

Race [check all that apply]

- ☐ White
- ☐ Black or African American
- ☐ Asian/Pacific Islander
- ☐ Alaskan Native/American Indian
- ☐ Hispanic
- ☐ Other: _____
- ☐ No answer

Age [Check one]

- ☐ Under 20
- ☐ 20-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60+

Profession: _____

Practice location: _____

3.3 Patient survey

Thank you for completing this short survey!

Gonorrhea and chlamydia, two common sexually transmitted diseases (STD), have been increasing in Alaska.

We want to know what you think are the best ways to prevent STDs in Alaska.

Your answers are anonymous.

This survey should take you about 10 minutes to complete.

If you have any questions about this survey, please call
Susan Jones, HIV/STD Program manager at the Alaska Division of Public Health, at 269-8061.

If you would like more information on STDs, please visit:

http://www.itsyoursexlife.com/gyt

www.cdc.gov/std/

PLEASE DO NOT PUT YOUR NAME ON THIS SURVEY.

1. If you found out you had an STD, how would you want your sex partner(s) to hear that they needed to get tested and treated? (*check one box*)
   - ☐ I would tell them myself
   - ☐ I would tell some of them myself and have a clinic or public health worker tell some of them
   - ☐ A clinic or public health worker would tell all of them
   - ☐ Other: _____

2. If you found out you had an STD, which of the following would you be willing to do to get your sex partner(s) tested and treated? (*check as many boxes as you want*)
   - ☐ Give them medicine from my healthcare provider
   - ☐ Give them a prescription from my healthcare provider
   - ☐ Bring them with me to see my healthcare provider to get tested and treated
   - ☐ Tell them to go to a clinic to get tested and treated
   - ☐ Tell my healthcare provider their name(s) so he/she could make sure they get tested and treated
   - ☐ Other: _____

3. If you were to tell your sex partner(s) to go to a clinic for testing and treatment, do you think they would go?
   ☐ Yes, all of them ☐ Yes, some of them ☐ No, none of them

4. If you were to ask your sex partner(s) to come with you to see your provider, do you think they would?
   ☐ Yes, all of them ☐ Yes, some of them ☐ No, none of them

5. If your healthcare provider gave you medicine or a prescription for your sex partner(s), who would you give it to? (*check one box*)
   ☐ All of my partners ☐ Only my main partner ☐ Only my casual partners ☐ Only partners that I thought had an STD ☐ None of my partners

6. If you were to give your sex partner(s) a prescription, do you think they would get it filled?
   ☐ Yes, all of them ☐ Yes, some of them ☐ No, none of them

7. If you were to give your sex partner(s) medicine for an STD, do you think they would take it?
   ☐ Yes, all of them ☐ Yes, some of them ☐ No, none of them

8. Which of the following are important reasons why you might **not** give a prescription or medicine to all of your partner(s)? (*check as many boxes as you want*)
   - ☐ I don't know how to find some of my partner(s)
   - ☐ I don't want to tell some/all of my partner(s) that I have an STD
   - ☐ I don't want my partner(s) to think I have other partners
   - ☐ I don't think my partner(s) would get a prescription filled
   - ☐ I don't think my partner(s) would take the medicine
   - ☐ I would keep some or all of the medicine for myself in case I need it later
   - ☐ Other:_____

9. Do you know the names of people you've had sex with in the last six months? (*check one box*)
   ☐ Yes, I know all of their names ☐ Yes, I know some of their names ☐ No, I don't know any of their names

Please turn over for a few more questions.

PLEASE DO NOT PUT YOUR NAME ON THIS SURVEY.

10. If you knew the name(s) of your sex partner(s), would you tell your healthcare provider their names to get medicine or a prescription for them? (*check one box*)
    - ☐ I would tell my provider the names of <u>all</u> of my partners
    - ☐ I would tell my provider the names of <u>some</u> of my partners
    - ☐ I would <u>not</u> tell my provider the names of any of my partners

11. If one of your sex partners gave *you* a prescription for medicine for an STD, would you get it filled? (*check one box*)
    ☐ Yes ☐ No

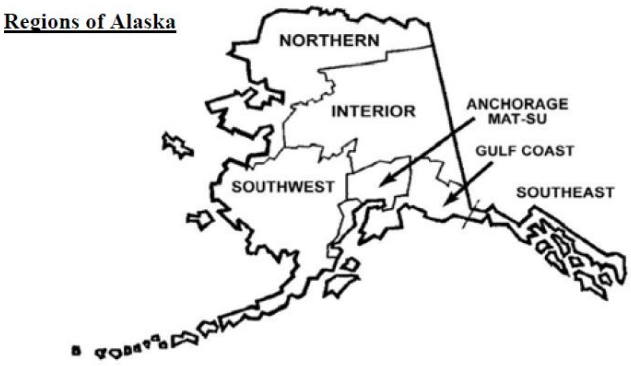
12. If one of your sex partners gave *you* medicine for an STD, would you take it? (*check one box*)
    ☐ Yes ☐ No

13. What ideas do you have to make it easier for sex partner(s) to get tested and treated for STDs?
    _____
    _____

14. What is your sex? (*check one box*)
    - ☐ Male
    - ☐ Female

15. What is your age? (*check one box*)
    - ☐ Under 20
    - ☐ 20-29
    - ☐ 30-39
    - ☐ 40 or older

16. What would you consider your race? (*check as many boxes as you want*)
    - ☐ Alaskan Native/American Indian
    - ☐ Asian/Pacific Islander
    - ☐ Black or African American
    - ☐ Hispanic
    - ☐ White
    - ☐ Other: _____



17. What region do you live in? (*check one box*)
    - ☐ Anchorage/Mat-Su
    - ☐ Southwest
    - ☐ Southeast
    - ☐ Interior
    - ☐ Gulf Coast
    - ☐ Northern
    - ☐ Other:_____

18. Which of the following best describes the size of your community? (*check one box*)
    - ☐ Less than 1000 people
    - ☐ 1000–5000 people
    - ☐ 5001–20,000 people
    - ☐ More than 20,000 people

Thank you! We appreciate your time and value your opinions!

3.4 Patient interview guide

Introduction

I'm ____ and I work for the Centers for Disease Control and Prevention. I am working with the Alaska Division of Public Health to help find ways to prevent sexually transmitted diseases (or STDs) in Alaska. We are talking to people in your community to get their opinions about some ways to get treatment to sexual partners of people who have an STD.

Thank you for agreeing to talk to me. We will not tell anyone about your recent infection, but we want to know about your experience getting your partners treated. I may take notes on what you say, but your name is not on this form. Your answers will be put together with answers from everyone else we are interviewing. You can answer or not answer any or all of these questions.

Are you ready to hear the questions?

Questions

1. When you were told about your infection, did anyone talk to you about getting your partners treated?

   Who talked to you?

   Do you think all, some or none of your partners were treated?

   If all or some: How did your partners get the medicine to be treated?

   If some or none: Why do you think some of your partners were not treated?

2. If your healthcare provider gave you medicine for <u>you</u> to give to your partners….

   a) Would you be willing to give them the medicine?

   b) Would there be some partners that you would not be able or willing to give the medicine?

   c) What might keep you from giving the medicine to all of your partners?

3. If your healthcare provider gave you a prescription for <u>you</u> to give to your partners….

   a) Would you be willing to give them the prescription?

   b) Would there be some partners that you would not be able or willing to give the prescription?

   c) What might keep you from giving the prescription to all of your partners?

   d) What might keep your partners from getting the prescription filled?

4. What do you think is the <u>best</u> way to get partners treated?

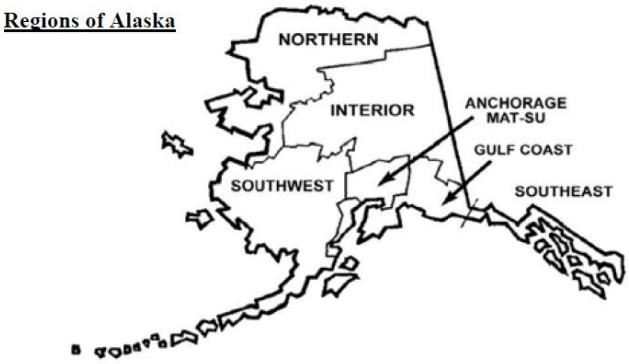
   Why is that the best way?

5. Is there anything else you'd like to tell us about how to prevent STDs in Alaska?

Demographics

20. What is your sex? (check one box)
    - ☐ Male
    - ☐ Female

21. What is your age? (check one box)
    - ☐ Under 20
    - ☐ 20-29
    - ☐ 30-39
    - ☐ 40 or older

22. What would you consider your race? (check all the boxes that apply)
    - ☐ Alaskan Native/American Indian
    - ☐ Black or African American
    - ☐ Asian/Pacific Islander
    - ☐ Hispanic
    - ☐ White
    - ☐ Other: _____

23. What region do you live in? (check one box)
    - ☐ Anchorage/Mat-Su
    - ☐ Southwest
    - ☐ Southeast
    - ☐ Interior
    - ☐ Gulf Coast
    - ☐ Northern
    - ☐ Other:_____