

Web-based Patient-Delivered Partner Therapy distribution increases in California¹, 2016

Background

Patient-Delivered Partner Therapy (PDPT)² is safe, reduces reinfection rates, is well accepted by patients, and has been legal in California since 2001 for CT and 2007 for GC.^{3,4,5} However, clinical practices still experience barriers to utilizing PDPT as a mechanism for partner treatment.

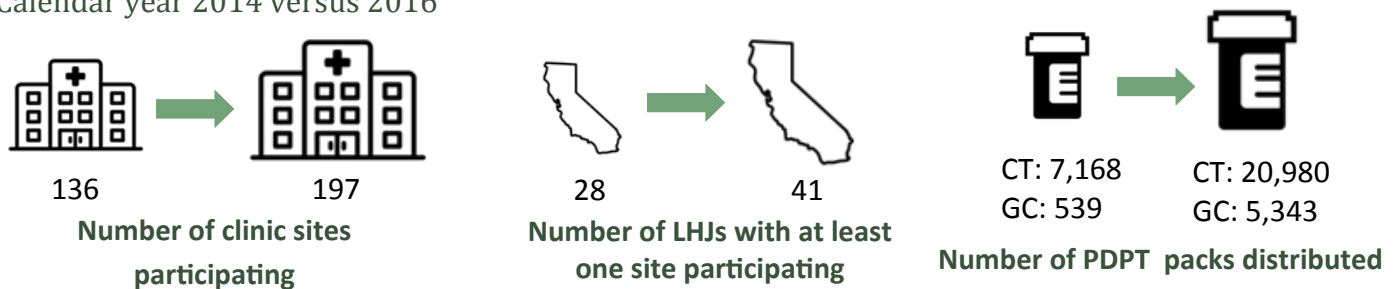
Since 2005, the California STD Control Branch (STDCB) has partnered with Essential Access Health to provide free, pre-packaged PDPT medications to eligible health centers. To facilitate expanded PDPT distribution, the program re-launched in September 2015 using a completely web-based platform for registration and ordering, and for reporting on medication distributed. Eligibility was also expanded beyond Title X family planning clinics and local health jurisdictions (LHJs) to include a range of other safety net clinical settings.

We evaluated the impact on PDPT program participation and PDPT pack distribution after the re-launch.




What was the impact to date?

PDPT program participation and PDPT pack distribution increased

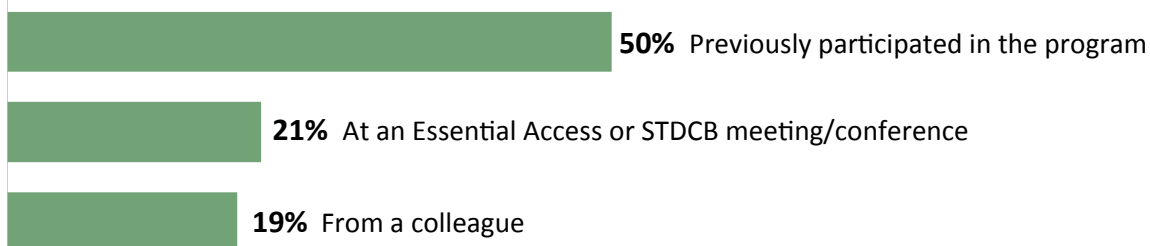
Calendar year 2014 versus 2016



Why was there an increase ?

- Our hypothesis:**
-  Increased ease of ordering through a web-based system
 -  Expanded eligibility criteria
 -  Increased marketing and promotion

How did agencies hear about the program?⁵



¹This program evaluation was limited to the 59 LHJs in the California Project Area, which includes all of California except San Francisco and Los Angeles counties.

² <http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/CA-STD-PDPT-Guidelines.pdf>

³Hosenfeld CB, Workowski KA, Berman S, et al. Repeat infection with Chlamydia and gonorrhea among females: a systematic review of the literature. Sexually transmitted diseases. Aug 2009;36(8):478-489.

⁴Trelle S, Shang A, Nartey L, Cassell JA, Low N. Improved effectiveness of partner notification for patients with sexually transmitted infections: systematic review. BMJ (Clinical research ed.). Feb 17 2007;334(7589):354.

⁵Schillinger JA, Gorwitz R, Rietmeijer C, Golden MR. (2016) The Expedited Partner Therapy Continuum: A Conceptual Framework to Guide Programmatic Efforts to Increase Partner Treatment. Sexually Transmitted Diseases. 43(2 Suppl 1):S63-75.

⁵Data collected via an online registration survey with 34 of 37 responses.

What barriers remain?



Programmatic barriers

- Marketing is **labor intensive**
 - * Identifying the best marketing venues and targeting promotion to the correct persons within a clinical setting is challenging
- Dispensing onsite often **requires staff training, leadership buy-in, and technical assistance**
 - * Health centers may require technical assistance to navigate complex logistics prior to participating (see case study insert)
- **Funding** challenges
 - * PDPT is not reimbursable by health plans, so public health funds and opportunities to purchase reduced-price drugs must be pieced together to provide free PDPT to health centers
 - * As a result, the program has at times experienced delays, temporary stoppages, and limitations on scale up due to budget constraints, medication shortages, etc.



Health center barriers

Why did agencies NOT participate?⁶

Didn't sign up for program (n=12)

Lack of onsite dispensing/pharmacy
Provider concerns about liability
Not a clinic priority
Difficulty meeting program requirements

Signed up but didn't register sites (n=5)

Difficulty establishing field delivered treatment programs
Missing necessary approvals

Signed up, registered, but didn't order medication (n=6)

Misunderstanding of program specifications

Case Study

The STD Program Manager in a rural LHJ had to go through internal administrative approval processes, apply for an onsite dispensing license with the state Board of Pharmacy, wait for approval to dispense treatment directly to index patients (a PDPT program participation requirement), and identify a pharmacist to conduct quarterly inspections before implementing PDPT in their county clinic.

What can be done to improve access to PDPT in California?

While the re-launch of the California PDPT program resulted in an increase in both participation and PDPT pack distribution, PDPT uptake statewide is still not to scale. In 2016, the California PDPT program provided 20,980 and 5,343 doses of CT and GC treatment, respectively, which represent a fraction of the 198,503 CT and 64,677 GC cases reported in California⁷ during this time period. Despite well-documented benefits to index patients' health as a result of reduced reinfection rates and community health benefits from interrupting ongoing transmission, there is currently no mechanism for health centers to seek direct reimbursement from health plans for PDPT.

In addition to funding challenges, a number of other barriers remain for the California PDPT program, ranging from labor intensive marketing to providers often requiring additional leadership support/buy-in and technical assistance to incorporate systems for implementing PDPT into their practice. Policy solutions are needed to bring PDPT to scale for population-level impact, in particular to assure sustainable payment sources outside of public health.

⁶Title X agencies and LHJs were asked about PDPT program participation barriers via a phone survey (n=23)

⁷California Project Area, which includes all of California except San Francisco and Los Angeles counties.