

are under way. There has been a gradual transition to acceptance and even support for the program.

The coordination of postrelease care is a challenge. Individuals going to correctional facilities not offering MAT (federal or out of state) have to be weaned off MAT. Release to the community is often unpredictable. However, individuals can immediately continue treatment because they are already enrolled as CODAC patients.

VIABILITY

The Rhode Island state budget for 2017 officially contained \$2 million for the implementation of the MAT expansion program and has been funded again through 2018. Governor Raimondo has highlighted the program's efforts as a significant component of her statewide overdose and addiction prevention plan.⁴

System-wide changes also ensure that the program will

become a part of RIDOC's standard health care services. Provider time has been increased and additional providers have been hired. To facilitate communication between administration, security, rehabilitative services, and medical staff, program leaders established an MAT process team. Members serving on the Governor's Overdose Prevention and Intervention Task Force provide the public insight on program challenges and changes.

CONCLUSIONS

The increase in illicit use of heroin and other illicit opioids is a serious public health concern. Despite justice-involved persons being especially vulnerable to overdose and relapse upon release, prisons and jails have been slow to allow this population access to MAT. Rhode Island's statewide comprehensive program expansion at the RIDOC

shows that MAT is feasible in correctional settings, and preliminary outcomes suggest strong rates of treatment retention after release. In the face of a severe public health crisis related to illicit opioid use, continuing and initiating MAT in correctional facilities with seamless linkage to care in the community should be a top priority for any community concerned about illicit opioid use and overdose deaths. *AJPH*

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Expedited Partner Therapy: Combating Record High Sexually Transmitted Infection Rates

Expedited partner therapy (EPT) is an underused practice to address the record high rates of sexually transmitted infections (STIs) in the United States. There were more than 1.59 million reported cases of chlamydia in 2016, the highest number of annual cases of any condition ever reported to the Centers for Disease Control and Prevention (CDC).¹

The continued increase in rates of chlamydia, gonorrhea, and syphilis is particularly surprising in light of the numerous gains that have been made in other

areas of reproductive health. Access to contraception has increased, unintended pregnancy rates have decreased, age at first sexual activity has increased, and access to online health information has continued to improve; so why are STI rates worsening?² The answer is not simple, although the lack of partner treatment plays an important role.

The transmission of undiagnosed STIs may result in persistent or recurrent infections and can cause serious health complications. Women are at

increased risk for pelvic inflammatory disease, chronic pelvic pain, and infertility.³ Untreated STIs also increase the risk of HIV acquisition.⁴ Adolescent women aged 15 to 24 years accounted for

46% of reported chlamydia cases in 2016.¹ Increasing rates among adolescents have the potential to diminish the reproductive health of future generations, as women with undiagnosed infections face serious health consequences.¹ In addition to this epidemiological burden, STIs also carry a significant economic burden. The total direct cost of chlamydia and gonorrhea in 2008 was \$516.7 million and \$162.1 million, respectively (on the basis of 2010 US dollars).⁵

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This continued increase in STIs has occurred despite several prevention and research programs and organizations dedicated to decreasing their prevalence and transmission (e.g., the Infertility Prevention Project, the CDC, HORIZONS, US Health and Human Services). The CDC recommends annual STI screening for chlamydia and gonorrhea for all sexually active women younger than 25 years.⁶ STI screening should be considered for men who report high-risk behaviors and in communities with a high burden of infection.⁶ Health care providers are expected to counsel individuals on safe sex practices, offer STI screening as indicated, and recommend the use of condoms to everyone. Despite these programs and recommendations, rates of STIs continue to increase—suggesting that these efforts are just not enough.

There are continued concerns regarding the availability of health care and the coverage of services, including annual STI screening and treatment. At-risk individuals without health insurance have diminished access to screening and treatment, leading to further increases in STI rates. However, EPT has the potential to reverse this trend by allowing health care providers to reach exposed individuals who would otherwise be unable to access health care services.

EXPEDITED PARTNER THERAPY

EPT is a health care practice that allows providers to give a prescription or medications to the heterosexual partners of patients diagnosed with chlamydia or gonorrhea without testing or examining the partner.⁷ Although EPT is not a substitute for

a full sexual health evaluation, partners of infected individuals often cannot or do not seek treatment. Of note, EPT is not recommended for the management of STIs in men who have sex with men because of the lack of data demonstrating EPT's effectiveness and the concern of missing STI and HIV coinfections in this population.⁷ EPT is endorsed by the CDC and the following professional health organizations: American Academy of Family Physicians, American Academy of Pediatrics, Society for Adolescent Health and Medicine, and American Congress of Obstetricians and Gynecologists. Most importantly, EPT is a patient-centered, effective solution that is cost-effective and safe.^{7,8}

WHERE EXPEDITED PARTNER THERAPY IS PERMISSIBLE

Several states enacted EPT legislation following the publication of the CDC's EPT guidelines on August 16, 2006.⁷ Currently, EPT is permissible in 41 states and the District of Columbia (a legal status of EPT map is available at <https://www.cdc.gov/std/ept/legal/default.htm>). With the passing vote on House Bill 360 in February 2017, Georgia became the most recent state to permit the practice of EPT. EPT is "potentially allowable" in seven states and Puerto Rico. EPT is currently prohibited in South Carolina and Kentucky.

IMPLEMENTATION CHALLENGES

Although EPT is largely permissible in the United States, states struggle with its implementation.

On the basis of each state's wording and varying interpretation of the law, the implementation and delivery of EPT may be limited and contribute to the increasing STI rates.⁹ There are obstacles to fully realizing EPT's potential at every level of health care (Figure A, available as a supplement to the online version of this article at <http://www.ajph.org>). Stigma affects STI screening and treatment and may limit both patients' willingness to divulge concerns and providers' willingness to initiate discussions regarding sexual health.¹⁰ Patients may not be aware of EPT and therefore cannot request it for their sexual partners or may not feel comfortable providing it to their partners. Partners may not fill the prescriptions (because of, e.g., high out-of-pocket cost, lack of insurance coverage) or take the medication after it is given to them.¹¹ Cost continues to be a barrier, as many insurance companies currently do not cover EPT. Many health care providers may not be aware of the availability of EPT or how to provide it in the context of their current practice.¹² Providers may also be resistant to prescribing EPT, as they may prefer to physically see or contact every patient.¹² Barriers in the health care infrastructure also limit EPT use, because pharmacies and electronic medical records are often not equipped to implement and support the widespread practice of EPT.

THE FUTURE OF IMPLEMENTATION

In light of rising health care costs and the increasing burden of STIs, strengthening the implementation of effective STI treatment and prevention strategies is critical to tackle the STI epidemic. This is most important

for high-risk individuals and communities with a high prevalence of STIs. Health care providers are at the front line of these efforts, including leading programs and policies to increase knowledge and usage of EPT. Additional research is warranted to improve the implementation of EPT, including research to further the understanding of the facilitators and barriers among health care providers and within complex health care systems. Training programs for physicians, nurses, and physician assistants could include education on the effectiveness and specific processes needed to provide EPT in their communities. Electronic medical records that remind providers and automate prescription of treatment of sexual partners concurrently with the index patient are promising advances to promote EPT uptake.

In addition to clinical practice, research is needed to understand what influences patient uptake of EPT, to understand effective ways to assist patients in educating their sexual partners, and to evaluate EPT implementation in high-risk populations, such as men who have sex with men and transgender individuals. In states where EPT is only potentially allowable or prohibited, clear communication of the efficacy of EPT on STI rates is needed to inform decision-making.

The United States is at a crossroads. STIs are rampant, especially among youths, and access to health care services continues to be limited for many. Although health care policies often lag behind clinical practice innovations, policies related to EPT are distinctly different. With 41 EPT-permissible states in the United States, health care policies are well aligned to meet the needs of patients. EPT provides

confidential and convenient treatment—two critical components of STI care. Therefore, it is time for state and local public health departments and health care providers to advance clinical processes and practice to fully realize the potential of EPT to address the worsening STI crisis. **AJPH**

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Ebola Virus Disease Preparations Do Not Protect the United States Against Other Infectious Outbreaks

The 2014–2016 West African Ebola virus disease (EVD) epidemic took the world by surprise. While 11 patients were treated in the United States, it challenged public health, health care, and emergency response infrastructures.¹ The outbreak highlighted the need for robust systems of screening and care for patients with highly hazardous communicable diseases (HHCDs), especially because the outbreak showed how modern travel hastens international disease spread. The May 2018 EVD outbreak in the Democratic Republic of Congo reinforces this need and demonstrates the uphill battle against emerging and reemerging diseases.

In the beginning of the 2014 outbreak, most health care facilities in the United States

were unprepared to identify, isolate, and provide care for patients who presented to their facilities with suspected EVD.¹ Responding to this deficiency, the United States, led by the Assistant Secretary for Preparedness and Response and the Centers for Disease Control and Prevention (CDC), developed a tiered EVD care system that outlined the minimum expected capabilities for frontline hospitals, assessment hospitals, and Ebola treatment centers.² Designated assessment hospitals and Ebola treatment centers collectively made significant modifications to their facilities to enhance infection control, purchased greater quantities of personal protective equipment, and enhanced staff training.³ In addition, the Assistant Secretary for Preparedness and Response designated and funded one

hospital in each of the 10 Department of Health and Human Services regions as a regional Ebola and other special pathogens treatment center (RESPTC), requiring these facilities to make more upgrades than the other two tiers to receive designation as first-choice locations to provide care for patients with confirmed EVD. These efforts resulted in significant progress in our domestic capability to safely care for patients with EVD.¹

CURRENT STATUS

After more than three years of efforts, and in light of the new EVD outbreak, policy-makers and the public likely expect that the United States will sustain the new capabilities that it has paid for and developed to care for patients with EVD. It is also likely they believe this infrastructure can safely be used to accommodate patients during future outbreaks of other HHCDs, such as Middle East Respiratory Syndrome and other viral hemorrhagic fevers, such as Lassa. It is true that the upgraded facilities, personal protective equipment, enhanced trainings, and disease surveillance, in tandem with updated federal guidance, bolstered funding,

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