News & Analysis

Medical News & Perspectives

A Proactive Approach Needed to Combat Rising STIs

Bridget M. Kuehn, MSJ

Emergency departments around the US are seeing a 39% increase in the number of visits related to sexually transmitted infections (STIs), according to a recent report from the CDC. The flood of patients ending up in the emergency department for STI care is just 1 symptom of a growing public health crisis.

After decades of progress at reducing sexually transmitted diseases (STDs), the United States is seeing a dramatic reversal of fortunes. The CDC has documented sharp increases in the number of cases of chlamydia, gonorrhea, and syphilis since 2013. Chlamydia remained the most common infection with 1.7 million—almost half of which affected young women. Total cases of STIs reached an all-time high of 2.3 million in 2017.

Audio

This growing epidemic results in more than $16 billion a year in costs associated with these illnesses, according to David Harvey, MSW, executive director of the National Coalition of STD Directors. Untreated, such infections can lead to poor pregnancy outcomes, infertility, chronic pelvic pain, and an increased risk of HIV infection.

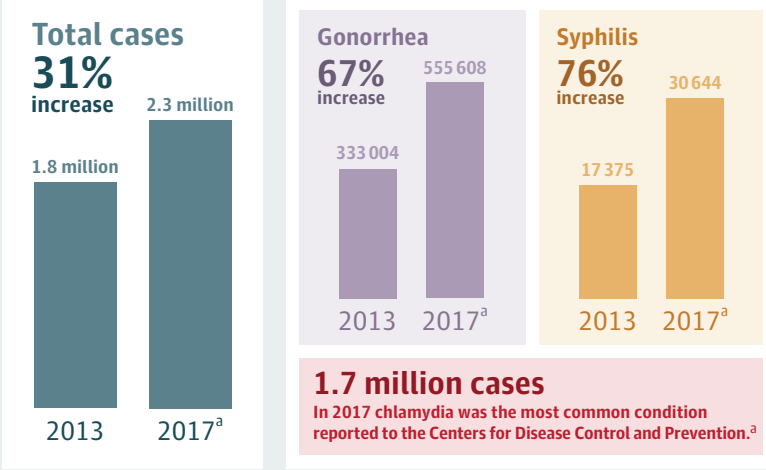
"We are sliding backward," said Jonathan Mermin, MD, MPH, director of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention in a statement. "It is evident the systems that identify, treat, and ultimately prevent STDs are strained to [the] near-breaking point."

Eroding public health infrastructure and funding are key contributors to the trend, along with a complex brew of social and economic trends, experts say. And reversing it will take a renewed commitment to public support for sexual health care, as well as a concerted effort by primary care clinicians to make sexual health a priority.

"Health care providers are just absolutely critical to this," said Laura Bachmann, MD, MPH, the medical director of CDC's Division of STD Prevention.

The United States is experiencing steep, sustained increases in sexually transmitted diseases.

Combined diagnoses of chlamydia, gonorrhea, and syphilis increased sharply over the past 5 years.



[a] Preliminary data

Centers for Disease Control and Prevention

Weakened Safety Net

Many factors are likely contributing to rising STI rates in the United States including changes in sexual practices and health disparities. But there is broad agreement among leaders in the STI field that a weakened system for safety net sexual health services is a major factor.

"We have let our public health guard down," said Cornelis Rietmeijer, MD, PhD, medical director of the Denver STD Clinical Prevention and Training Center, part of a network of centers funded by the CDC to train clinicians. "We're relying on primary care, we're relying on family planning, we're relying on emergency departments. At the same time, we've kind of let the quality of our publicly funded STD clinics go by the wayside."

Local STD clinics play an essential role in prevention and care. Some patients choose STD clinics over their regular physician because of stigma or privacy issues, while others may lack money or access to care elsewhere, said Hunter Handsfield, MD, professor emeritus of medicine at the University of Washington Center for AIDS and STD and former director of the Sexually Transmitted Diseases Control Program in Seattle.

"They tend to attract people whose risks are among the highest in the community," Handsfield said. "Therefore, they drive the epidemic in everyone else."

These clinics also provide specialized expertise, particularly on more complicated-to-treat infections like syphilis, Handsfield noted. They track local STI trends and develop control strategies. They may also have resources to do partner outreach.

Yet funding for federal, state, and local programs that provide STI prevention services has stagnated. According to the National Coalition of STD Directors, a decline in the CDC's STI prevention budget from about $168.5 million in 2003 to about $157.3 million currently has reduced the program's purchasing power by 40%.

More than 60% of local health departments report recent budget cuts that led to STD clinic closures, reduced clinic hours, staff reductions, or new or increased co-pays for STI screening or care. And a 2016 CDC report suggests that fewer clinics and reduced services are associated with rising rates of STIs.

"All of those things have been found to have a relationship to increasing STD rates as one would suspect when you don't have optimal access to those resources," Bachmann said.

Indirect cuts to family planning clinics and policy shifts aimed at curtailing abortions at family planning clinics that receive federal funding for other services may also have inadvertently reduced access to STI prevention and treatment, noted Elizabeth Nash, a policy analyst at the nonprofit Guttmacher Institute in Washington, DC.

"It's a roundabout way of trying to go after abortion, but in fact what's happening is an undercutting of the safety net clinics," Nash explained. As a striking example, the closure of a Planned Parenthood clinic serving rural Scott County, Indiana, in 2013, which resulted from funding cuts, may have contributed to the 2015 HIV outbreak associated with injection opioid use in the area, Nash noted. The clinic had been the only source of free HIV testing in the county.

It's not yet clear whether the ongoing opioid epidemic is driving the spread of other STIs. The CDC is evaluating evidence that opioid use may increase the risk of other sexually transmitted infections, Bachmann said.

"We think it's not necessarily or directly related," Bachmann said. "[However,] we do see these connections between opioid and other drug use with these sexual behaviors and STD rates."

Handsfield explained that substance use may contribute to individuals trading sex for money or drugs or simply not taking preventive measures.

"Sexual health diminishes in importance in the presence of such life stressors," he said.

Other trends may also contribute. For example, success at combating the spread of HIV and preventive strategies like preexposure prophylaxis may inadvertently be leading to the spread of other STIs.

"The success of fighting the big bad STD, HIV, has led to far less condom use, partner selection based on HIV status without protection and without regard to other STDs," Handsfield said. "That's a critically important element in driving the dramatic rise of syphilis and gonorrhea in men."

Worsening socioeconomic conditions and disproportionately higher rates of incarceration of minority men may also be contributing to rising STIs in some communities. For example, more risky sexual behaviors have been associated with a history of incarceration or unstable housing among black men.

"It's not a surprise that poverty, unemployment, substance use, and economic stress drive sexual behavior trends," Handsfield said. Reversing these trends will require not only more investment in public health, he said, but also a commitment to addressing larger socioeconomic issues.

Proactive Care: Express Testing

To stem the rising tide of STIs, clinicians at STD clinics and in primary care settings around the country are turning to new proactive approaches to increase STI screening and treatment.

Rietmeijer and his colleagues at the Denver Metro Health Clinic were among the first in the United States to implement the idea of an express clinic for STI testing. The addition of co-pays for examinations at their clinic had prevented many patients from accessing care. So Rietmeijer and his colleagues began offering low-risk patients (asymptomatic without injection drug use or high-risk sexual behaviors) a free express option. The express option skipped the physical examination and had patients collect their own samples for testing. It was modeled after Dean Street Express, a self-serve STI testing clinic in London.

"It hasn't only increased the access but also efficiency in the clinic," Rietmeijer said, with express visits saving time for patients. A study found that implementation of an express option at an Australian STI clinic increased the number of patients seen by 11%, reduced per-patient costs, and decreased wait time.

Express visits also improve patient satisfaction. He explained many patients are embarrassed that they may have an STI or because they fear a partner has been unfaithful. Being able to skip an invasive examination and have their results in a few days is a relief.

The idea has caught on at clinics around the country. To help identify and advance best practices, the CDC is funding the National Association of County and City Health Officials (NACCHO) to lead an express clinic initiative. Fifteen STD clinics around the country are participating by sharing experiences and discussing how they've adapted their clinic flow, billing, electronic medical records, and other systems to accommodate express visits, said Samantha Ritter, MPH, a senior program analyst at NACCHO who is managing the program. Three clinics are also receiving onsite technical support. Ritter and her colleagues plan to share their findings next year. They also plan to assess some outcomes.

"Through this project we are able to explore and support approaches to modernize

clinic operations, improve efficiencies and patient care, and ultimately drive down new STI infections," said Gretchen Weiss, MPH, director of HIV, STI, & Viral Hepatitis at NACCHO.

Primary care clinicians also have an important role to play. Bachmann suggested starting with following CDC guidelines for STI screening and treatment. The guidelines recommend yearly chlamydia screening for sexually active women younger than 25 years. But currently, only half receive such screening, said Edward Hook III, MD, a professor at the University of Alabama and director of the STD Control Program for the Jefferson County Department of Health.

"Sex is part of life, so it's part of primary care and health care in general to talk about these sorts of issues," Bachmann said. She and Rietmeijer suggested borrowing from the express clinics' play book and make self-collection of samples for yearly testing a routine part of primary care.

Myth Busting and Other Tools

Hook, who helps train physicians at the STD Prevention Training Center for Alabama and North Carolina, said there are widely held misconceptions about STIs among physicians and patients. For example, some wrongly associate STIs with promiscuity or think that STIs will be obvious to the clinician or patient, he said. Neither are true. He noted that most women with chlamydia had just one partner in the previous year.

"Women, who are at the highest risk for chlamydia, are at risk because they have an asymptomatic male partner who doesn't know that he is infected," Hook explained.

Another common misconception is that patients will be offended if their physician asks about sexual health or offers STI testing, Hook said. He noted many patients find it reassuring.

"[This discussion] includes not only assessing and potentially screening for sexually transmitted infections but also sex education, family planning, thinking about reproductive cancers," Hook said.

Besides addressing the sexual health of patients, the CDC recommends that clinicians provide treatment for a patient's sexual partner sight unseen when the patient tests positive for an STI to prevent reinfection. Nash noted that 37 states currently allow such partner treatment. Based on the limited data available, Bachmann said, the CDC thinks only about 10% of clinicians offer expedited partner treatment. She suggested that physicians familiarize themselves with the laws governing their practices.

"It does require a change in thinking in terms of the traditional practice of prescribing medication only to the patient in front of you," she said. But "when we don't treat partners effectively, that ultimately will impact the patient."

For physicians who want to learn more about partner STI treatment and other tools to combat STIs, there are educational offerings through the CDC's STD Training Centers or online courses. They can also consult with experts in their region about difficult cases online through the STD Clinical Consultation Network.

"Talking about these issues takes practice," Bachmann said. "Just opening the conversation and making it routine, over time the comfort level grows." ■

Note: Source references are available through embedded hyperlinks in the article text online. Accompanying this article is the JAMA Medical News Summary, an audio review of news content appearing in this month's issues of *JAMA*. To listen to this episode and more, visit the JAMA Medical News Podcast.

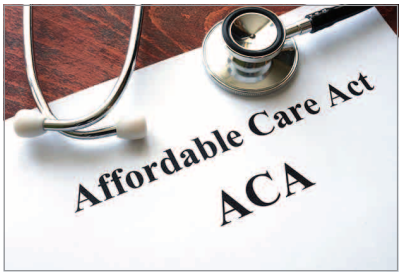
The JAMA Forum

Texas v United States: The Affordable Care Act Is Constitutional and Will Remain So

Lawrence O. Gostin, JD

On December 14, 2018, in a widely reported decision, a federal judge in Texas ruled that the entire Affordable Care Act (ACA) is unconstitutional. The judge reasoned that since the ACA's "individual mandate" is unconstitutional, the rest of the law cannot stand without it. However, the ACA will remain in place pending appeal, and it is highly unlikely that this ruling will stand.

The ACA in 2010 created an individual mandate to expand health insurance coverage, along with Medicaid expansion and subsidies for moderate and low-income households. The mandate required most Americans to maintain "minimum essential" coverage, enforced through a "shared responsibility payment" in the form of a tax. The Supreme Court in *National Federation of Independent Business v Sebelius* (2012) upheld the individual mandate as within Congress' power to tax. (It rejected the commerce power as a constitutional justification for the mandate.)



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Challenging the Individual Mandate

In December 2017, Congress enacted the Tax Cuts and Jobs Act, which reduced the tax penalty to $0. That action effectively eliminated the individual mandate. Thereafter, 18 Republican state attorneys general and 2 GOP governors challenged the constitutionality of the individual mandate. They went further, urging the court to strike down the entire ACA, including 2 pivotal, highly popular reforms: "guaranteed issue" (insurers must cover all applicants, irrespective of preexisting conditions) and "community rating" (insurers cannot charge individuals higher premiums based on their health status).

Usually, the administration defends existing law, but in an unusual move, the Department of Justice declined to fully defend the ACA. Instead, it argued that the court should invalidate the preexisting condition protections. It argued that "guaranteed issue" was so closely tied to the individual mandate that both should be overturned. Several distinguished