Background Bacterial STI testing is a necessary component of sexual health care for MSM living with and at risk for HIV. Guidelines recommend testing at least once a year or more often if at ongoing risk. As part of a larger mixed methods study with the overall goal to prioritize new STI testing interventions, our aim was to determine barriers and facilitators to offering bacterial STI testing among healthcare providers in Toronto, Canada.

Methods In 06/2018–07/2018, we circulated invitations for an online, anonymous survey to an estimated 172 providers in Toronto. Providers were eligible if they provided care for ≥1 MSM per week and were involved in the decision-making process in providing a STI test (e.g., taking sexual histories, ordering tests).

Results Of 93 respondents, 68% worked in primary care, 32% worked in public health/sexual health clinics, 70% were physicians and 30% were nurses or other allied health professionals. Most (67%) saw between 1 and 30% were nurses or other allied health professionals. Among respondents working in primary care (n=63), barriers to offering testing sometimes or more often were: insufficient consultation time (64%), difficulty introducing testing during unrelated consultations (52%), forgetting to offer testing (46%), patient reporting no sexual activity (30%) and patient refusal (25%). Among all respondents, preferred practice changes to improve testing were: express testing/fast-track testing services (89%), provider alerts when patients are due for testing (87%), self-collected specimen sampling by patients (84%), standing orders for tests (79%), and nurse-led STI testing (78%). Primary care providers were more in favour of provider alerts whereas providers at sexual health clinics favoured patient reminders.

Conclusion Among those whose practice incorporated sexual health care for MSM, providers were in favour of initiatives to simplify and expedite bacterial STI testing (including self-collection of samples), prompts/reminders for testing, and expanding testing delivery to other healthcare professionals.

Disclosure No significant relationships.

Background Adolescents account for 1 in 4 sexually transmitted infections (STIs) diagnosed annually in the United States. Many adolescents seek care in emergency departments (ED) for acute medical problems which offers an opportunity to screen for risk behaviors including sexual health. As emergency medicine provider time is focused on the acute medical problem, using technology may be an acceptable and effective alternative to identify and decrease screening risky sexual behaviors.

Methods Adolescents aged 13–18 years participated in a randomized controlled trial of an electronic health behavior screening and feedback tool in a pediatric emergency department. All participants were surveyed about risky behaviors at the baseline ED visit and 3 months later, and only intervention arm participants received immediate individualized electronic feedback about their risk behaviors, normative comparisons and brief educational information, including on birth control and condoms. In this secondary analysis, we used Chi-squared analyses to compare differences in 3-month STI risk defined as sexually active and reporting inconsistent condom use.

Results A total of 296 adolescents including 55% females enrolled in the study with 72% (n=212) completing the 3 month follow-up survey. At baseline 23% (69/296) reported ever having sex and 67% (46/69) reported using a condom at last sex. At follow-up 16% (17/105) of the intervention group and 23% (25/107) of controls reported having sex in the last 3 months. Of those sexually active, 35% (6/17) of intervention group participants compared to 56% (14/25) of control group reported not always using condoms in the last 3 months (p=0.19). STI risk at 3 months was 6% (6/105) for intervention participants compared to 13% (14/107) for controls (p=0.07).

Conclusion Electronic sexual health screening in the emergency department increases opportunities to assess, identify, and intervene in risky sexual behaviors in adolescents and may contribute to a decrease in risky behaviors.

Disclosure No significant relationships.
sexual health service in Birmingham, UK has provided free online home-based sampling in addition to a clinic-based service. The objectives of the study were to: • assess whether there were differences between the groups accessing screening online and in clinic; • evaluate the health outcomes associated with screening by setting; • analyse the interactions between online services and clinic-based services in terms of patient usage, and changes in access over time.

Methods A retrospective analysis of the clinic and online databases was undertaken to identify patients who undertook home-based and clinic-based testing between January and December 2017. Statistical analyses were undertaken to assess the uptake of screening by population group and identify predictors of screening uptake in different settings.

Results Overall 31,901 online testing kits were requested, with 18,087 returned, which equated to 14,667 patients. In the same period, 44,047 appointments were conducted in clinic, for 36,209 patients. A higher proportion of patients accessing online screening compared to clinic-based services were female (66.3% vs 52.1%, p<0.001), aged <25 (52.5% vs 41.5%, p<0.001), white (74.4% vs. 40.1%, p<0.001), asymptomatic (79.6% vs. 49.4%, p<0.001), and a lower proportion were from the two most deprived socio-economic groups (38.8% vs. 50.5%, p<0.001). There were also differences in positivity rates for chlamydia and gonorrhoea (7.25% vs. 9.98% and 1.53% vs 3.47%, p<0.001).

Conclusion This study provides valuable insights into differences in patient characteristics between those accessing online and clinic based services. This knowledge will allow those involved in planning and delivering services to understand how different service elements can complement each other. Our findings can be used to ensure that digital health services are integrated effectively alongside other types of services, in the context of limited resources, both in the UK and internationally.

Disclosure No significant relationships.

Understanding young people's priorities for sexually transmitted infection (STI) screening

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Abstracts

Understanding young people’s priorities for sexually transmitted infection (STI) screening

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Background It is important that STI screening provision reflects the priorities of young people, as they bear the greatest burden of disease. Such provision has become possible in a wider range of settings but there are constraints due to budget pressures. The objectives of the study were: • To assess how young people prioritise different characteristics of STI screening; • To analyse whether there are differences across socio-demographic groups; • To predict participation rates for different service configurations.

Methods Eight qualitative focus groups were used to design a discrete choice experiment (DCE) to analyse the choices made by young people. DCEs are an attribute-based survey method which involve respondents making choices between hypothetical scenarios, comprising two or more alternatives. The DCE included the following service characteristics: waiting times for appointments, waiting times for results, type of consultation, staff attitude, type of screening test, STIs tested for, and setting. The DCE was administered to 2000 young people who were part of an online panel in the UK, with quotas set to ensure inclusion of minority ethnic groups.

Results Analyses indicated that all seven service characteristics investigated were statistically significant factors for participants. Feeling that staff were non-judgemental was the most important characteristic to young people. Being tested for all STIs, having a full consultation and getting results quickly were also characteristics identified as important. Further analyses revealed some heterogeneity in priorities by gender, ethnicity and age group.

Conclusion This study provides valuable insights into the service characteristics that are seen as the most important by young people. This knowledge will allow those involved in providing and designing services to understand the relative importance of different service characteristics. At a time when sexual health services are facing pressures, such findings can be used to inform service development to ensure that decision-making is informed by young people’s priorities.

Disclosure No significant relationships.

ESTIMATING NEONATAL HERPES SIMPLEX VIRUS INFECTIONS USING CHAPMAN’S CAPTURE-RECAPTURE METHOD, FLORIDA, 2011–2017

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Background Neonatal infection with Herpes Simplex Virus (nHSV) is a reportable condition in Florida. Healthcare providers are required to report cases of nHSV, and clinical laboratories are required to report the results of tests in which HSV is detected. However, electronic laboratory reporting (ELR) to the Florida Department of Health is incomplete, and results are not captured in the repository used for case-based reporting of other nationally reported sexually transmitted infections. We estimated the incidence of laboratory-confirmed nHSV in Florida using provider-reported cases alone, ELR alone, both provider and ELR reports, and the incidence yielded by a capture-recapture methodology.

Methods Provider-reported cases of nHSV (infants ≤60 days of age with HSV infection confirmed by culture or polymerase chain reaction) during 2011–2017, and laboratory reports of HSV-positive culture or PCR results in the same age group, over the same period, were extracted and analyzed. Provider-reported cases were matched with ELR results using name, date of birth, and specimen collection dates. Chapman’s estimator for capture-recapture was used to estimate nHSV incidence in Florida. Rates of nHSV infections per 100,000 live births were calculated.

Results Providers reported 113 nHSV cases and ELR identified 197 nHSV cases during 2011–2017. Of these, 44 cases were common to both datasets, leaving 266 unique nHSV reports. Given the number of unmatched cases, Chapman’s estimator suggests 501 (95% C.I. 401–600) nHSV cases occurred in Florida during the study period. The incidence of nHSV using