Results Although participants welcomed the male-centred intervention, some felt that the voucher amount was too small. Overall, many participants described the voucher, EPIC-HIV, and the convenience and privacy of home-based testing as 'catalysts' to test or link to care irrespective of their reported intrinsic motivations to know their status or concerns around HIV related sexual risk behaviours. One-third of the interviewees were first-time testers. Despite the incentives, two out of the five men who tested positive reported that they have not linked to care because they feared stigmatisation at local clinics.

Conclusion Generally, the HITS intervention influenced men's motivation to test and access care, but some respondents felt the incentive was insufficient to overcome some barriers of accessing HIV care at fixed clinics. To achieve the 90–90–90 targets among men in our setting, provision of decentralised, non-judgmental and convenient incentivised HIV care services could increase uptake of HIV testing and treatment.

Disclosure No significant relationships.

P013 SCREENING PRACTICES RELATED TO INCONCLUSIVE *NEISSERIA GONORRHOAE* AND *CHLAMYDIA TRACHOMATIS* NUCLEIC ACID AMPLIFICATION TESTING

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Background Given rising incidence of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* (GC/CT), development of efficacious screening strategies is critical. While guidelines recommend nucleic acid amplification testing (NAAT) for GC/CT screening, a small proportion of NAAT results are inconclusive - resulting in delays in diagnosis and treatment. Our study seeks to determine rates as well as provider- and patient-related factors associated with inconclusive NAAT results with the goal of developing improved screening practices.

Methods This is a cross-sectional, case-control study of individuals with inconclusive GC/CT NAATs at a single institution (University of California, Los Angeles) from 3/2016–6/2018. Clinical charts were abstracted for age, gender, HIV status, PrEP use, STI screening (GC/CT and syphilis), anatomic site of sample collection (urogenital, pharyngeal, or rectal), and whether repeat testing occurred within 6 months following an inconclusive result. Cases were defined as a specimen that resulted in inconclusive GC and/or CT NAAT. Controls were specimens randomly selected from all non-inconclusive samples that underwent GC/CT NAAT during the study period and were matched with inconclusive specimens by type (rectal, urine, or genital). Patient-level characteristics associated with inconclusive GC/CT testing were analyzed with Chi-square and logistic regression.

Results During the study period, 6.1% (852/14,048) rectal, 0.3% (313/91,092) genital, and 0.01% (155/137,783) urine samples were inconclusive for one or both of GC and CT; no pharyngeal samples yielded inconclusive results. Among patients with inconclusive GC/CT NAAT, 64.6% (441/683) received repeat testing within six months, of which 6.4% were positive, 82.8% (365/441) negative, 10.7% (47/441) inconclusive, and 0.2% (1/441) indeterminate. While diabetes was associated with inconclusive urogenital GC/CT NAAT,

HIV status, PrEP use, and positive STI screening were not associated with inconclusive results.

Conclusion Despite having a clinical indication to receive GC/CT screening, fewer than two-thirds of inconclusive results were repeated, potentially missing an opportunity to interrupt the infection cycle.

Disclosure No significant relationships.

P014 VALIDATING A CLINICAL PREDICTION RULE FOR CHLAMYDIA AND GONORRHEA INFECTION AMONG ONLINE TESTERS IN BRITISH COLUMBIA, CANADA

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Background Clinical prediction rules (CPRs) estimate the probability of a health outcome to support decision-making in intervention and service delivery. Previously, a CPR was derived to maximize detection of chlamydia and/or gonorrhea (CT/GC) infections and minimize the number of screening tests offered among asymptomatic women and heterosexual men attending sexually-transmitted infection (STI) clinics in Vancouver, British Columbia, Canada. We assessed the external validity of using this clinic-derived CPR within GetCheckedOnline (GCO), a provincial online STI testing program in British Columbia.

Methods Data used for calculating CPR scores, including age, race/ethnicity, number of sexual partners and previous CT/GC diagnoses, were collected prospectively on GCO from October 2015 to June 2018. Model calibration and discrimination were evaluated using the Hosmer-Lemeshow (H-L) statistic and the area under the receiver operating characteristic curve (AUC), respectively. Sensitivity and proportion of GCO clients screened were calculated at different CPR cut-off scores. In the original derivation population, the CPR had an AUC=0.74, with a cut-off risk score ≥ 6 identifying 91% of infections and screening 68% of testers.

Results Among 2703 GCO CT/GC test episodes, the prevalence of CT/GC infection was 2.1%. The clinic CPR showed reasonable calibration (H-L $p=0.952$) and discrimination (AUC=0.64, 95%CI: 0.57–0.71). Using a CPR cut-off risk score of ≥ 6 , we would have detected 79% of infections and screened 64% of testers. Lowering the cut-off risk score to ≥ 4 would have increased sensitivity to 95% while screening 85% of testers.

Conclusion This is the first study validating the use of a clinic-derived CPR within an online setting. Our CPR showed reasonable accuracy and performance when applied to GCO data. Differences in model performance online compared with clinic-based settings highlight important differences in the populations who use online testing. Use of CPRs in online contexts offers unique and novel opportunities for public health and STI testing.

Disclosure No significant relationships.