elevated rates of unprotected vaginal sex (UVS) among a sample of YBM at high risk of STI/HIV acquisition.
Methods: Young Black males 15-23 years of age experiencing recent penile-vaginal sex were recruited from STI clinics in three U.S. cities for an NIH-funded randomized controlled trial of a safer sex intervention program. Baseline data were used for this analysis. An audio survey was administered which assessed condom use behaviors, participants' desire, and perceptions of partners' desire, for pregnancy. The correlate (Pregnancy Desire) was created by combining items into a trichotomy (No Desire, Discrepant Desire, Mutual Desire). Bivariate associations between the trichotomy and two dichotomous outcomes (any UVS and any condom breakage) and two continuous-level outcomes (frequency of UVS and proportion of condom-protected penile-vaginal sexual encounters) were detected using Chi-Square and one-way ANOVA respectively. Multiple logistic regression was used to calculate odds ratios for the association of the trichotomy with dichotomous outcomes, adjusted for age and report of multiple sex partners. Multiple linear regression models were used to calculate age-adjusted, and multiple partner-adjusted, Beta values for each of the assessed correlations.
Results: "No Desire" to conceive was associated with significant differences in UVS, condom breakage, frequency of UVS and condom usage compared to each of the other groups. Logistic regression demonstrated any UVS was 2.81 times more likely amongst Mutual Desire and 1.85 times more likely amongst Discrepant Desire Groups compared to the No Desire Group. Multiple linear regression models controlling for age and multiple sex partners demonstrated a positive significant Beta for frequency of UVS and negative significant Beta for proportion of condom use suggesting the proportion of condom use increases as group membership progresses from Mutual Desire to No Desire.
Conclusions: Findings from this study of 578 YBM attending STD clinics support the concept that YBM trying to conceive or who perceive somebody wants to be pregnant with their child are relatively unlikely to use condoms, despite STI/HIV risks. In planning public health interventions consideration must be given to the outcomes demonstrating YBM may be both yielding to or disregarding the desires of their female sex partners regarding conception. This suggest a potentially beneficial behavioral intervention model to avert HIV/STI acquisition amongst YBM may be dual-prevention, structurally addressing motives for and perceptions about conception with the necessity of protecting a high-risk population against an ever-expanding epidemic of STIs, including HIV.
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120.

EXPEDITED PARTNER THERAPY AND STI AWARENESS

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Purpose: Chlamydia and gonorrhea have the highest rates among the 14-24 year old age group. Per the CDC and SAHM, health care providers should be screening for these diseases at every opportunity. To prevent reinfection, expedited partner therapy (EPT) came into clinical practice in 2006. The CDC defines EPT as the clinical practice of treating the sexual partner of those diagnosed with chlamydia or gonorrhea without the healthcare provider examining the partner. A pilot study performed at the Illinois Chapter of the American Academy of Pediatrics (ICAAP) demonstrated many barriers to the use of EPT. The goal of this study is to further look at the rates of STI screening and EPT usage by pediatric providers in the primary catchment area of Advocate Children's Hospital – Oak Lawn, and identify any barriers to screening or treatment in order to increase awareness and suggest solutions for the future.
Methods: Data were collected as part of a three-phase analysis. Phase 1 involved the distribution of a provider survey to address EPT use, STI screening and barriers to care (n = 44). In addition, a survey for teens (ages 12-24) was distributed to five pediatric clinics in the immediate catchment area (n = 59). Phase 2 involved focus groups with pediatric providers to better delineate the barriers identified. Phase 3 involved creating a community asset map and a STI/EPT toolkit for providers. The data obtained was analyzed for any trends in STI screening, EPT use, and patterns in reported barriers among providers. The teen data was analyzed and compared to provider results for STI screening and utilized in the development of the resource toolkit.
Results: The majority of providers (81.8%) reported that they offer STI screening and diagnosis, in contrast to the minority of teens (10.8%) who indicated that they had been screened for STIs. Along with the findings regarding STI screening and diagnosis, the data indicated that there are a limited number of physicians (25%) who utilized EPT in their practice citing a number of barriers to its use. The top three barriers reported by providers were 1) uncomfortable treating a patient never seen before (77.1%), 2) treating an STI without screening for others (55.4%), and 3) liability (45.7%). While there is a minority of providers who currently utilize EPT in their practice, the majority of providers (86.8%) are willing to participate in an EPT training program.
Conclusions: While pediatric providers are offering STI screening and diagnosis, adolescents are not being screened per CDC recommendations. EPT has proven to be an asset in reducing STI rates and in turn long term complications. While providers are not currently utilizing EPT, there is interest in starting. To increase health care provider comfort levels, our group has distributed a toolkit containing informational documents. In conjunction with STI/EPT toolkit, our team has assembled an asset map for the described catchment area, which includes clinics/pharmacies that provide STI screening, diagnosis and treatments. Further research will be needed to determine the efficacy of our project.
Sources of Support: CATCH Grant ID 2104.

121.

IMPROVING SCREENING FOR SEXUAL ACTIVITY AND STIS AMONG ADOLESCENTS IN URBAN PRIMARY CARE: RESULTS OF A LEARNING COLLABORATIVE APPROACH TO QUALITY IMPROVEMENT

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Purpose: Sexually transmitted infections (STIs) remain a significant source of morbidity among adolescents. Many infections are

asymptomatic, but pose significant risk for long-term sequelae. Urban communities, including the Bronx, are disproportionately affected. Primary care providers are well positioned to identify and treat STIs, yet many adolescents are not screened. The purpose of the Bronx Ongoing Pediatric Screening (BOPS) project is to improve rates of screening across 4 domains (newborn genetic, metabolic and infectious diseases; infant/toddler screening for developmental and social/emotional disorders; school age and adolescent mental health; and STIs) in a large Bronx primary care network. We report changes in screening for sexual activity and STIs (N. Gonorrhea, C. Trachomatis [GC] and HIV) among youth age 13-19.

Methods: Intervention: BOPS, launched in March 2011, combines a modified learning collaborative, real-time clinical data feedback to practitioners and staff, quality improvement coaching, and a pay-for-quality monetary incentive using multidisciplinary onsite teams. Design: Comparison of 10 BOPS-participating sites (intervention) to 8 non-participating sites (control). Setting: A hospital-owned ambulatory network in the Bronx, NY. Main Outcomes/ Measures: Rates of assessing sexual activity and ordering GC and HIV testing as documented in the adolescent template of the shared EMR; results of screening abstracted from the hospital's clinical information systems.

Results: Baseline rates of screening for GC and HIV varied across practices (16% to 84%, and 33% to 68%, respectively.) Between March 2011 - May 2013, the quarterly rate (median of weighted averages) of documented sexual activity during visits (in the EMR adolescent template) increased from 37% to 84% at BOPS sites and from 7% to 62% at non-BOPS sites. Among youth with sexual history documented as sexually active, quarterly screening rates for GC increased from 67% to 86% at BOPS sites and from 38% to 78% at non-BOPS sites. Among sexually active youth, HIV screening increased from 54% to 74% at BOPS sites and from 33% to 70% at non-BOPS sites. Among all youth with a visit to a BOPS site (not only those with documented sexual history), the annual proportion of GC tests to individuals increased from 15.4% pre-intervention [2010] to 19.8% in 2011, and to 34.7% in 2012. The proportion steadily increased for males (2010-12.3%, 2011-16.4%, 2012-25%) and females (2010-17.9%, 2011-22%, 2012-42.8%). At non-BOPS sites, the proportion of GC tests to individuals also improved from 12.1% pre-intervention to 14.7% in 2011 and 23.8% in 2012; the proportion increased less for males (2010-9.8%, 2011-11%, 2012-16.4%) than for females (2010-14%, 2011-17.8%, 2012-30.3%).

Conclusions: Our findings demonstrate that focused quality improvement (QI) efforts involving learning collaboratives, improvement coaching, EMR-generated data feedback and multidisciplinary teams improve documentation of sexual activity and increase rates of STI screening for both male and female adolescents. Data from non-participating sites suggests that introduction of an adolescent template in the EMR results in improvement in screening rates regardless of participation in the BOPS collaborative; BOPS activities appear to promote additional improvement, especially for screening of adolescent males.

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122.

ELEVATED SEXUAL RISK BEHAVIORS AMONG POST-INCARCERATED YOUNG AFRICAN AMERICAN MALES IN THE SOUTHERN UNITED STATES

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Purpose: Young African American males continue to be disproportionally likely to acquire sexually transmitted infections (STIs) including Human Immunodeficiency Virus (HIV). This problem is exacerbated in the Southern U.S. STI rates are consistently higher for incarcerated or recently arrested persons including youth compared to those never incarcerated. However few studies have specifically examined the sexual-risk taking behaviors of young African American males post-release from incarceration. The purpose of this study was to determine whether young African American males, residing in the Southern U.S., who had been incarcerated in the past, reported recent sexual behaviors that were relatively more risky than their counterparts who had never been incarcerated.

Methods: African American males 15-23 years of age experiencing recent sexual intercourse were recruited from STI clinics in three Southern U.S. cities for an NIH-funded randomized controlled trial of a safer sex intervention program. Baseline data were used for this analysis. An audio survey was administered which assessed sexual risk behaviors and history of incarceration. Bivariate associations were conducted utilizing t-tests for continuous sexual risk behaviors and contingency table analysis for dichotomous sexual risk behaviors. Subsequently, a series of linear regression models were used to create age-adjusted associations for continuous sexual risk behaviors and incarceration history. Similarly, a series of logistic regression models were used to create age-adjusted associations for dichotomous sexual risk behaviors.

Results: 607 participants completed surveys. Past incarceration was strongly associated with all continuous-level outcomes for sexual risk-taking behaviors except, number of partners in past 2 months. Young men having experienced incarceration had more occurrences of sexual intercourse where alcohol or drugs were used (P Value = .001), and more episodes of unprotected sex (mean = 5.57 vs. 0.45 respectively, P = .015) compared to those never incarcerated. Significant positive associations were demonstrated between past incarceration and exchange of sex for drugs ($P < .001$) or money (P = 0.007). Interestingly there was a significant negative association between past incarceration and sex with male partners in the preceding two months (P = .02). History of past incarceration did not influence self-report of past positive gonorrhea or chlamydia testing (P = .25). Linear regression controlling for age demonstrated, past history of incarceration was independently predictive of alcohol use before sex, being high while having sex, frequency of unprotected sex and desire to conceive a pregnancy ($P < .001$, $< .001$, and = .005 respectively). Additionally, number of sex partners in the past 2 months trended toward significance (P = .09). History of incarceration remained negatively predictive for sex with male partners (AOR .51). Past incarceration remained strongly predictive of exchange of sex for drugs or money (AOR = 1.32, P = .001 and AOR = 2.23, P = .01 respectively). Self report of past positive gonorrhea or chlamydia test results remained non-significant.

Conclusions: Young African American males with history of incarceration demonstrated consistently significantly increased sexual risk-taking post incarceration compared to their never incarcerated peers. These insights are important because they can be used to