

their parents reported knowing this. Seventy-six percent of teens who had engaged in neither oral nor vaginal sex had a parent who reported this knowledge. Overall, 65% of parents accurately reported if their adolescent had engaged in oral or vaginal sex (congruence). Parent-teen sexual health communication was associated with congruence (OR 2.9). Congruence was also associated with teen comfort discussing sexual health, number of sexual health topics discussed, age of teen at first sexual health conversation, teen gender, and teen age. Teens who reported talking to their parents about sexual health were 5.2 times more likely to report any condom past three months compared to those who did not report sexual health communication with their parent.

**Conclusions:** To design appropriate interventions aimed at improving parent-teen sexual health communication, it is important to assess not only if parents are talking to their teens about sexual health topics, but also whether communication results in accurate knowledge about teen behavior. Parental knowledge of teen sexual behaviors appears to be a marker of communication quality between parent and teen and can therefore serve as a tool by which researchers can evaluate sexual health communication. Improving such communication may increase healthy sexual behaviors among teens.

**Sources of Support:** None.

## HEALTH POLICY, QUALITY IMPROVEMENT, AND LEGAL/ETHICAL ISSUES

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### PROVIDER ATTITUDES, KNOWLEDGE AND PRACTICE OF EXPEDITED PARTNER THERAPY (EPT) FOR ADOLESCENTS TREATED FOR CHLAMYDIAL INFECTION IN VARYING STATE POLICY ENVIRONMENTS

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**Purpose:** Adolescents in the United States are disproportionately affected by sexually transmitted infections (STIs). Expedited Partner Therapy (EPT), treatment of the sexual partner(s) of a patient with an STI without intervening clinical exam or professional counseling, is effective in preventing reinfection, but is not used frequently for adolescents. The purpose of this study was to evaluate provider knowledge of state legal policy around EPT, current practice, and potential barriers to provision of EPT.

**Methods:** Anonymous, closed-ended, computer-based survey administered via REDCap software to randomly selected providers in the AMA database who care for adolescents and practice in one of three differing state legal environments. States were grouped based on a revised framework from the CDC as follows: EPT is (A) explicitly legal (NY, OR, TN); (B) permissible but not directly referenced in law (PA, MS, NV); or (C) potentially allowable (NJ, GA, MT). Survey items assessed provider demographics; knowledge of EPT legal environment in physician's practicing state; provider attitudes around EPT and potential barriers to provision of EPT in adolescents ages 13–17. Analyses were performed using STATA 12.0.

**Results:** Emails were sent to 7789 physicians; of the 1710 (22%) opened emails there were 195 evaluable responses. 61% were female; 83% spent at least three-quarters of their time in clinical

practice. The majority (59%) completed a pediatrics residency and 5% completed an adolescent medicine fellowship. With respect to state policy groupings, 44% practiced in group A, 31% in B, and 24% in C. Only 20% reported a history of using EPT; those in group A were more likely to have used EPT compared to groups B and C (OR 5.5, 95% CI 2.3, 14.2). Half in group A correctly reported EPT was legal in their state; 22% in group C incorrectly stated EPT was legal in their state; and 88% in group B reported they did not know about legality. 63% reported they were supportive of EPT for adolescents; providers in group A were significantly more likely to report supporting EPT than those in groups B and C (OR 2.6, 95% CI 1.3, 5.2). Commonly cited barriers to EPT were missed opportunity to counsel partners (82%), difficulty insuring delivery of medication (79%), and concern the partner may not understand contraindications (77%); results did not differ by state grouping. Few participants were concerned that EPT violates medical practice guidelines (19%). Very few (13%) agreed with the statement, "there are other laws or policies in my state or institution that would make it difficult to provide EPT"; with group B least likely to agree.

**Conclusions:** Results suggest that despite positive attitudes towards EPT, the treatment is not commonly used for adolescents. Although those providers in supportive state legal environments were more likely to use EPT, providers in all policy environments had similar concerns about barriers to EPT. Further investigation is needed to better understand the impact of laws on EPT practices. Ultimately, this will inform policy recommendations and intervention development to increase provision of EPT to adolescents.

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### BRIEF ELECTRONIC SCREENING FOR ADOLESCENTS IN PRIMARY HEALTH CARE

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**Purpose:** The use of alcohol, tobacco, and other drugs (ATOD) among adolescents has been an ongoing public health concern for decades. The 2009 National Survey on Drug Use and Health (NSDUH) estimated that 21.8 million Americans aged 12 or older were current illicit drug users, about 8.7% of the population. The call for healthcare providers and primary care settings to become more active in the prevention and treatment of ATOD among adolescents has been made for over a decade and is especially important with the advent of the Affordable Care Act (ACA). The American Academy of Pediatrics strongly supports the use of screening, brief intervention, and referral to treatment with adolescents; however, providers and staff are concerned with screening negatively impacting clinic flow. The purpose of this study was to explore the use of electronic screening in adolescent specialty care clinics to assess the feasibility of their use.

**Methods:** Data were collected as part of the Adolescent Electronic Preventive Screening in Primary Health Care Settings pilot study. Participants ages 10–21 (68% female) completed a brief electronic screener in an adolescent primary care clinic prior to being seen by a physician (N = 98). The average age of adolescents screened was 16.3 years old, with the primary reason for visit was either a checkup or follow up. After completing the screener, and before having contact with any health care provider, printed results from the screener were given to the nursing staff and physician to