Assessing Recent Adolescent Sexual Risk Using a Sexual Health History Calendar: Results From a Mixed Method Feasibility Study

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HIV and other sexually transmitted infections (STIs) represent a significant ongoing public health challenge in the United States. Adolescents account for nearly one third of all new HIV infections (Centers for Disease Control and Prevention [CDC], 2011) and half of all other STIs (Weinstock, Berman, & Cates, 2004). STIs can pose serious long-term health consequences for young people and increase HIV risk (CDC, 2009).

Teen public health clinics may provide a key opportunity for prevention efforts that can reach youth who are at greatest risk for STI/HIV, including young people who are transient, under- or uninsured, and youth of color. Accurate assessment of patient risk behaviors is critical in these settings and a key component of risk-reduction planning. Typical standardized risk assessment surveys, long utilized for their quick and easy administration, persist in health care settings despite well-documented limitations. In addition to concerns surrounding retrospective recall (Belli, 1998; Ostrow, Kessler, Stover, & Pequegnat, 1993), the closed-ended question format does not facilitate the active formation of insight into patient patterns of risk or enhance patient–provider interactions. Longer, more in-depth interviews are often not feasible in clinic settings due to the time required to administer them.

The Sexual Health History Calendar (SHHC) was developed to address several of these challenges. In collaboration with staff and administrators at a public teen health clinic, the SHHC was created to address concerns that the standard risk assessment survey in use at the site did not consistently yield accurate risk histories for their adolescent patients. An additional concern was that the completed surveys were not useful for guiding development of risk-reduction plans during brief consultations with patients. The SHHC possesses several characteristics that can enhance the ability of health care providers to collect accurate information about risk taking while facilitating development of contextually based risk-reduction plans. It is based on the Life History Calendar method (also referenced as Event History Calendars [EHC]), which facilitates retrospective recall (Belli & Callegaro, 2009; Freedman, Thornton, Camburn, Alwin, & Young-DeMarco, 1988) and provides an opportunity for respondents to visually examine and reflectively evaluate their autobiographical reports (Axinn, Pearce, & Ghimire, 1999).

In their seminal work, Martyn and colleagues (Martyn & Martin, 2003; Martyn, Reifsnider, & Murray, 2006) explored use of an EHC for assessing 5- to 10-year sexual risk histories with adolescent females 15 to 19 years of age in a clinic setting. Study findings suggested that this type of calendar-based instrument was easy for patients and providers to use, could enhance recall of events, and could facilitate patient–provider discussions of risk. In

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a subsequent study, Martyn and colleagues (2011) explored the EHC impact on sexual risk communication, awareness, and behavior among a small sample of male and female adolescents 15 to 19 years of age, finding that the EHC might have important benefits for adolescent risk reduction.

Building on this important work, this two-phase pilot study explored the use of a self-administered calendar-based instrument to assess sexual risk behavior during each of the previous 12 months with a diverse sample of male and female adolescents in an urban clinic setting. The instrument was designed to assess risk independently for each month to facilitate examination of the specific ways in which adolescent risk fluctuated throughout the year. This research brief reports preliminary findings related to the first study aim, which was to develop and test the feasibility of the self-administered SHHC instrument in the clinic setting. Specifically, this article addresses SHHC completion rates, quality of data collected, acceptability for youth, and provider appraisal of the instrument and implementation process. Implications for risk-reduction planning and future use of the instrument in other clinical settings are discussed.

Methods

Study Design

In Phase 1 of this cross-sectional study, the self-administered SHHC instrument was developed and tested with an initial sample of youth ($n = 110$) seeking sexual health services. In Phase 2, the SHHC instrument was minimally revised based on preliminary results and feedback from youth and providers and was tested with a similar sample of youth ($n = 122$). Instrument piloting was conducted by a single staff person (a nurse, M. B.) to minimize clinic burden and maintain consistency during feasibility testing. The data collection schedule was established based on clinic staffing patterns; pilot data were collected on consecutive weekdays.

Sample

The study site, a publicly funded teen health clinic in a mid-sized midwestern city, provides health and mental health services to youth ages 12 to 22 years. The clinic serves more than 2,500 young people each year; patients are predominantly urban youth of color who are low-income and have either publicly-funded or no insurance.

A convenience sample ($n = 232$) was drawn from youth seeking services related to STIs at the clinic. The sample was 77% female and predominantly youth of color (56% Black, 22% White, 22% other youth of color [biracial, Hispanic, and Native American]). Youth ranged in age from 14 to 21 years old (mean = 18.6, $SD = 1.8$).

Procedures

Study procedures were incorporated into the standard clinic process to minimize disruption to clinic flow. During check-in, youth completed intake forms and a standard risk-assessment survey. Patients were examined by a nurse practitioner who obtained consent and provided participants with the SHHC and supplemental survey to complete in a second, more secluded waiting room. Participants then met with the designated provider (M. B.) who reviewed the completed SHHC with each potential participant in her office, addressed any areas inadvertently left blank on the calendar, added clarifying comments or additional detail when needed, and corrected any inaccuracies identified by the participant. The nurse then read aloud the 16 items from the nurse follow-up questions and noted each patient's responses on the SHHC. All provider comments were made using red pen to distinguish from those of respondents. Participants received a $5 gift card to a local retail store. The University of Minnesota Institutional Review Board approved study procedures and measures.

Measures

SHHC. The SHHC provides a visually intuitive calendar-based assessment of co-occurring risk behaviors anchored by contextual cues from other life domains, which includes important personal life, family, school, and work events. The SHHC was based on a longer, interviewer-administered life history calendar instrument created by the first author for a previous study on adolescent identity