

Demonstration Site Summary

Wellness Web 2.0

Coastal Bend Wellness Foundation

Corpus Christi, TX

In the Ryan White HIV/AIDS Program (RWHAP), Part F: Special Projects of National Significance (SPNS) Initiative

Use of Social Media to Improve Engagement, Retention, and Health Outcomes along the HIV Care Continuum

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March 2020

This publication was made possible by award number [H97HA28888](#) from the U. S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's Special Projects of National Significance Program. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. government.

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Executive Summary

The Coastal Bend Wellness Foundation (CBWF), a Federally Qualified Health Center in Corpus Christi, Texas, serves Texas's Health Region 11 where youth and young adults (ages 15-34) account for 57% of all new HIV diagnosis. CBWF was funded by HRSA through a Special Project of National Significance to implement and evaluate an innovative, technology-based intervention designed to increase linkage and retention in care among hard-to-reach youth and young adults living with HIV. CBWF developed, implemented, and evaluated the Wellness Web 2.0 program, which consists of a text-message adaptation of the evidence-based intervention Anti-Retroviral Treatment and Access to Services (ARTAS), health education text messages, and appointment reminders. These principal components of Wellness Web 2.0 target the following specific points along the HIV Care Continuum:

1. Linkage to care or re-engagement into care: the text-message adaptation of ARTAS provides social support and navigation assistance services aimed at linking recently diagnosed participants or re-engaging out-of-care participants to HIV health care services.
2. Retention in care: health education text messages provided encouragement for healthy living, reminded participants of the importance of regular HIV medical care follow-ups, and provided information on ancillary services to support retention in care. Participants also received medical appointment reminders.
3. ART treatment adherence and achievement of viral load suppression: health education text messages reminded patients of the important of treatment adherence. Participants also had the option to opt-in to receive medication reminders.

To ensure successful implementation and monitor process, impact, and outcomes, Wellness Web 2.0's monitoring and evaluation plan encompassed multi-layered data sources which include social media outreach data, testing data, client-level data, and EHR data.

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Introduction

Wellness Web is an SMS text message program that utilizes strengths-based social support, health education and navigation services to support linkage and retention in care for people living with HIV (PLWH) between the ages of 13 and 34. Wellness Web consists of three components which address the diverse needs of clients with varying healthcare engagement levels. The first component of Wellness Web supports linkage to care by adapting the evidence-based intervention Anti-Retroviral Treatment and Access to Services (ARTAS), which is traditionally delivered in-person, to be delivered through text message. The second component of Wellness Web, Mobile Wellness, supports clients' adherence to HIV treatment by delivering educational and encouraging text messages based on the Health Resources and Human Administration's (HRSA) UCARE4LIFE text message library (HRSA, 2016), medication reminders, and appointment reminders. The third component of Wellness Web is the navigation services that are available throughout the program based on individual clients' need for additional support.

According to the CDC, in 2016, 8,451 youth received an HIV diagnosis in the United States (CDC, 2018). Eighty percent (6,776) of those diagnoses occurred in persons aged 20-24. Additionally, 81% (6,848) of newly diagnosed youth were gay or bisexual males. Of newly diagnosed males, 47% (4,002) were black, 22% (1,821) were Hispanic/Latino, and 15% (1,254) were white. Among youth living with HIV in the United States in 2014, 41% received HIV medical care in 2014, 31% were retained in HIV care, and 27% had a suppressed viral load—the lowest rate of viral suppression for any age group (CDC, 2018).

According to the Texas Department of State Health Services, 2,729 youth aged 15-34 years old received an HIV diagnosis in 2016 (DSHS, 2017). Youth and young adults made up 61% of the total number of persons diagnosed (DSHS, 2017). Men who have sex with men (MSM) made up 72% of the total number of new diagnoses in 2016. Of newly diagnosed youth and young adults, 32% (863) were black males, 15% (407) White male, and 38% (1025) were Hispanic/Latino male (DSHS, 2017).

Youth and young adults face significant challenges in managing their HIV healthcare including the effects of stigma on their social support systems, ability to access healthcare and adherence to medication. In a 2012 Kaiser Family Foundation survey, 84% of youth aged 15 to 24 said there is stigma around HIV in the United States (Kaiser, 2012). Those who are hesitant to disclose their status to a parent or guardian due to feared negative reactions may be accessing health care services on their own for the first time and become overwhelmed by the process. In addition, young adults are more likely to have limited income and transportation, no insurance, or a "functional" loss of insurance if they do not want the primary beneficiary of the plan notified (Dowshen & D'Angelo, 2011). Young adults who have experienced stigma also reported having missed one or more clinic appointments and skipping medication doses (Venable, et. al., 2006).

Mobile health interventions are believed to be effective due to increased access to smartphone technology across all demographics. According to Pew Research Center, 65% of Americans owned a smartphone of some kind in 2015 (Pew Research Center, 2015). In addition, people have incorporated smart phones into many aspects of their everyday lives. 97% of smartphone owners used text messaging

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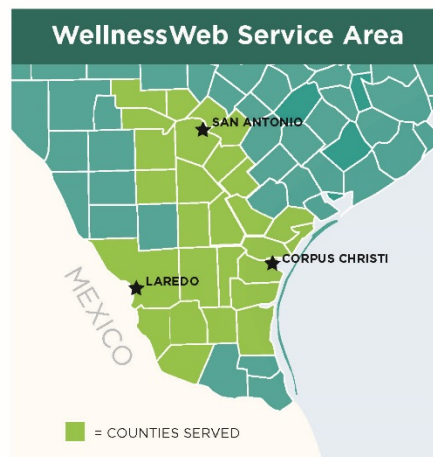
and 91% of smartphone owners age 18-29 used social networking at least once throughout the course of Pew Research Center's study (Pew Research Center, 2015). Additionally, 62% of smartphone owners have used their phone in the past year to look up information about a health condition (Pew Research Center, 2015).

Target Audience

The target population for this intervention are adolescents and young adults who are newly diagnosed with HIV, who know their HIV+ status, but have been out of care, and/or are not virally suppressed and are in need of support for retention in care and medication adherence. This intervention is primarily designed to support clinical work in community health care settings, public health clinics, and other health care setting serving similar populations who might have limited access to other kinds of support services. Organizations should have sufficient resources to work with clients enrolled in Wellness Web for up to 6-months. Wellness Web is not appropriate to be adapted or delivered in criminal justice settings such as jails or substance abuse treatment facilities where clients would have limited to no access to text messaging or social media messaging.

Rationale and Description of Need/Scope of Problem.

Wellness Web was implemented by the Coastal Bend Wellness Foundation (CBWF) located in Corpus Christi, TX, and worked in partnership with the San Antonio AIDS Foundation in San Antonio, TX and the Laredo Health Department in Laredo, TX. Through these collaborative efforts, Wellness Web served clients throughout 27 Texas counties.



Corpus Christi Health Service Delivery Area (HSDA)

The Wellness Web program was developed by the Coastal Bend Wellness Foundation (CBWF), a federally qualified health center with a 30-year history of providing health care and support services to people living with HIV. CBWF is based in Corpus Christi, Texas, the county seat of Nueces County and the

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eighth most populous city in the state of Texas. The Corpus Christi Health Service Delivery Area (HSDA) covers 11,000 square miles and 12 counties including Aransas, Bee, Duval, Jim Wells, Kennedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, and San Patricio. CBWF is the only HIV health care provider in the Coastal Bend region. In 2013, the Corpus Christi service area had a population of 597,898 and was characterized by a higher percentage of minority individuals (52.3%), lower median household income (\$46,499) and a high percentage of persons living below the poverty level (See Table 1).

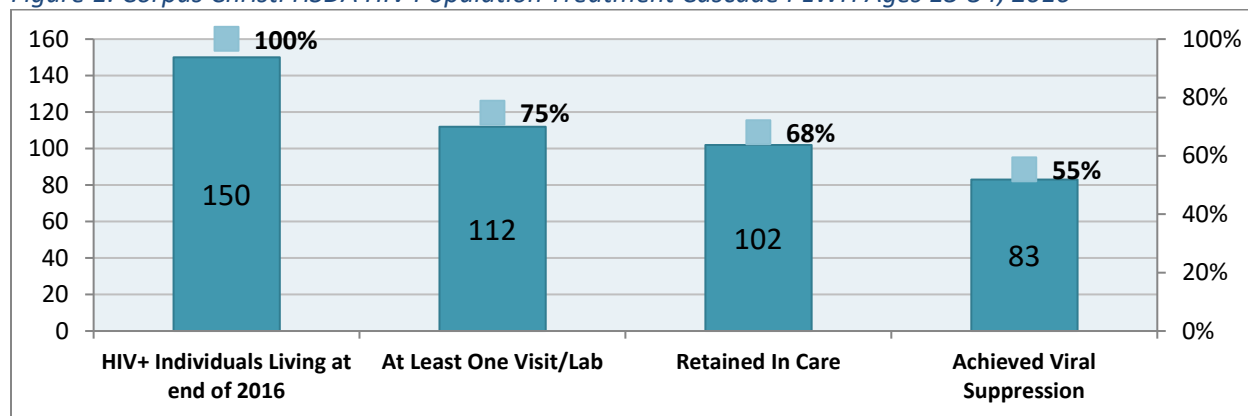
Table 1: Texas Health Facts Profile, 2013

County Name	Total Population	Hispanic Population Total (%)	% Below Poverty Level	Total Persons Without Health Insurance, Ages 18-64
Aransas	25,350	5,690 (24.6)	17.0	4,090
Bee	32,874	17,906 (56.2)	20.5	4,108
Brooks	7,230	6,590 (91.2)	34.7	1,254
Duval	11,388	10,424 (88.5)	24.5	1,823
Jim Wells	41,382	32,254 (79.0)	20.7	6,660
Kenedy	407	319 (76.7)	22.8	62
Kleberg	31,857	22,495 (70.2)	23.8	5,615
Live Oak	12,229	4,060 (35.2)	15.9	1,566
McMullen	820	261 (36.9)	8.8	82
Nueces	359,715	206,293 (60.6)	17.0	62,144
Refugio	7,289	3,487 (47.2)	15.8	1,045
San Patricio	67,357	35,248 (54.4)	14.3	10,512

Source: Texas Department of State Health Services (DSHS). (2013). Health Facts Profile, 2013. Center for Health Statistics.

At the end of 2016, there were a total of 847 individuals living with HIV (PLWH) in the Corpus Christi HSDA. Of those, 42 were newly diagnosed with HIV (DSHS, 2017). Youth and young adults under the age of 34 accounted for 17.7% of PLWH in 2016. Of those youth and young adults living with HIV in 2016, only 68% were retained in care and 55.3% of them were virally suppressed (See Figure 1).

Figure 1: Corpus Christi HSDA HIV Population Treatment Cascade PLWH Ages 13-34, 2016



Source: Texas Department of State Health Services (DSHS). (2017). Corpus Christi HSDA HIV Population Treatment Cascade PLWH Ages 13-34, 2016. Prepared by TX/HIV/STD Epidemiology and Surveillance Branch. August 2017.

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The Coastal Bend Wellness Foundation serves 8,000 youth and young adults with HIV within the target area. On a yearly average, CBWF provides medical care to 800 individuals living with HIV. Due to the study’s limited enrollment period and the low pool of eligible clients served at CBWF, it was necessary for evaluation purposes to expand the service area for the Wellness Web program. CBWF partnered with the Laredo Health Department in Laredo, Texas and the San Antonio AIDS Foundation in San Antonio, Texas to increase enrollment opportunities. Laredo and San Antonio were chosen as collaborators for this program due to the similarity of population demographics, comparative population sizes, positivity rates, and pre-existing partnerships with CBWF.

Laredo HSDA

The Laredo Health Department houses an HIV/AIDS program that provides testing, risk reduction counseling, case management, housing assistance and medical care. Laredo HSDA consists of four counties along the Texas-Mexico border: Jim Hogg, Starr, Webb, and Zapata (See Table 2).

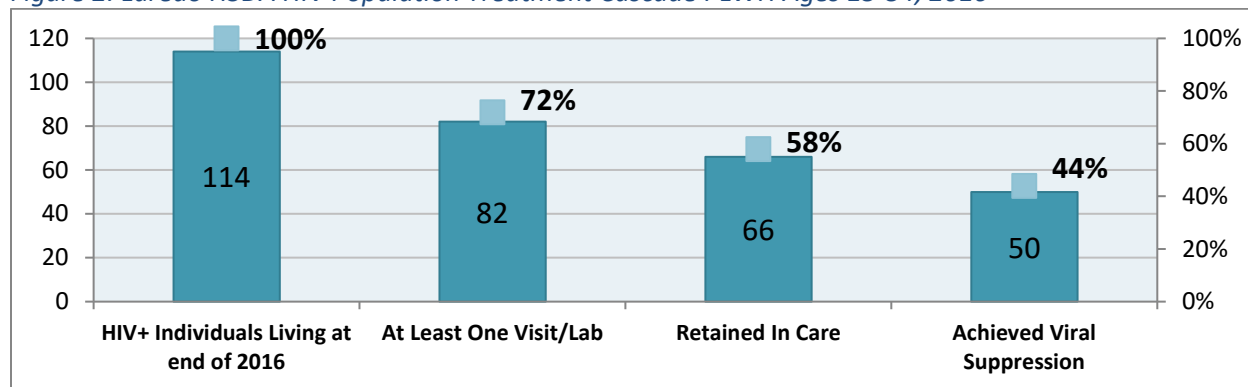
Table 2: Texas Health Facts Profile, 2013

County Name	Total Population	Area in Sq. Miles	Hispanic Population Total (%)	% Below Poverty Level	Total Persons Without Health Insurance, Ages 18-64
Jim Hogg County	5,236	1,136.1	4,853 (92.7)	24.0%	6,660
Webb County	266,443	3,356.8	255,511 (95.9)	30.6%	70,210
Zapata County	14,354	996.8	13,475 (93.9)	29.5%	3,536

Source: Texas Department of State Health Services (DSHS). (2013). Health Facts Profile, 2013. Center for Health Statistics.

There were 466 people living with HIV (PLWH) in this area at of the end of 2016. In 2016, 30 people were newly diagnosed with HIV. Youth and young adults under the age of 34 accounted for 24.4% of PLWH. Of those youth and young adults living with HIV in 2016, only 57.9% were retained in care (See Figure 2).

Figure 2: Laredo HSDA HIV Population Treatment Cascade PLWH Ages 13-34, 2016



Source: Texas Department of State Health Services (DSHS). (2017). Laredo HSDA HIV Population Treatment Cascade PLWH Ages 13-34, 2016. Prepared by TX/HIV/STD Epidemiology and Surveillance Branch. August 2017.

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San Antonio HSDA

The San Antonio AIDS Foundation provides comprehensive services to those affected by HIV/AIDS in Bexar County and 10 surrounding Texas counties.

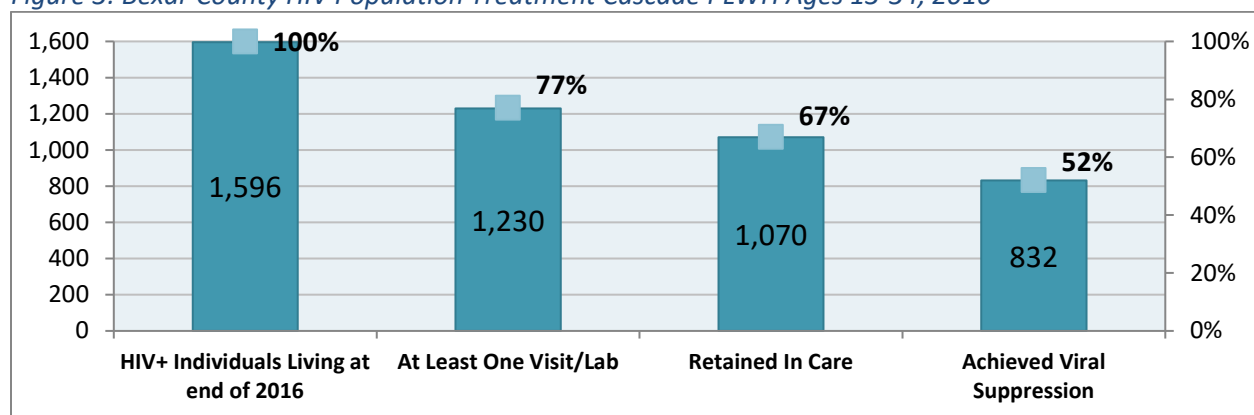
Table 3: Texas Health Facts Profile, 2013

County Name	Total Population	Area in Sq. Miles	Hispanic Population Total (%)	% Below Poverty Level	Total Persons Without Health Insurance, Ages 18-64
Atascosa County	47,125	1,232.1	29,630 (62.9)	17.8%	8,114
Bandera County	20,942	791.7	3,696 (17.6)	16.2%	3,260
Bexar County	1,813,421	1,246.8	1,085,562 (59.9)	17.4%	307,074
Comal County	118,373	561.5	30,009(25.4)	10.5%	16,289
Frio County	18,175	1,133.0	14,215 (78.2)	31.0%	2,549
Gillespie County	25,695	1,061.1	5,435 (21.2)	13.0%	4,178
Guadalupe County	143,195	711.1	52,587 (36.7)	11.0%	21,126
Karnes County	15,067	750.3	7,598 (50.4)	23.2%	1,599
Kendall County	37,673	662.4	8,078 (21.4)	8.5%	4,949
Kerr County	50,827	1,106.1	12,735 (25.1)	15.9%	7,656
Wilson County	45,680	807.0	17,727 (38.8)	11.3%	6,259

Source: Texas Department of State Health Services (DSHS). (2013). Health Facts Profile, 2013. Center for Health Statistics.

San Antonio AIDS Foundation provides testing, case management, mental health counseling, medical care, housing, and a year-round hot meal program. At the end of 2016, there were 1,596 PLWH between the ages of 13-34 in this area. In 2016, 228 people between the ages of 13-34 were newly diagnosed with HIV. Of those youth and young adults living with HIV in 2016, only 67% were retained in care and 52% achieved viral suppression (See Figure 3).

Figure 3: Bexar County HIV Population Treatment Cascade PLWH Ages 13-34, 2016



Texas Department of State Health Services (DSHS). (2017). Bexar County HIV Population Treatment Cascade PLWH Ages 13-34, 2016. Prepared by TX/HIV/STD Epidemiology and Surveillance Branch. August 2017.

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Wellness Web 2.0 Intervention Overview

As a mobile health intervention, Wellness Web provides participants with a digital safe space to discuss their HIV healthcare and available resources. Wellness Web reduces the burden placed on participants by removing the time and money associated with traveling to traditional, in-office support program appointments. Also, the amount of participant involvement required steadily decreases throughout the program as it transitions from one-to-one, live conversations to a push text message strategy.

Wellness Web uses Facebook, Twitter, Instagram, and social networking apps (Grindr, Jack’d, Scruff, Adam4Adam, Growlr) to outreach, engage, and recruit participants from the target population. At enrollment, participants provide comprehensive social media contact information to staff, regardless of connectivity, to help facilitate on-going communication. If participants do not have access to a phone, Wellness Web can provide eligible participants with a cell phone and a cellular service for up to six months. Once enrolled, Wellness Web delivers a mobile adaptation of ARTAS through a HIPAA compliant, secure text messaging service. Staff are available to provide one-on-one, live text messaging support to youth and young adults linking to medical care. Wellness Web also delivers 12-weeks of automated health education text messages to support clients’ adherence to and retention in HIV treatment, medication reminders, and appointment reminders.

Wellness Web activities center all social media activities around the six domains presented in The Texas HIV Plan (2012-2014) which was based on HRSA’s HIV Continuum of Care (see chart below). Wellness Web will address the needs of the target population across the care continuum as follows:

HIV Care Continuum Domains	Wellness Web Strategy
Public Awareness	Tailor social media HIV education and prevention messages to youth and young adults that are relevant in mode of delivery and cultural preferences and disseminate via multiple social media platforms (Facebook, Twitter, Instagram) and Social Networking apps (Grindr, Growlr, Jack’d, Scruff, and Adam4Adam).
HIV Diagnosis	Utilize social media platforms and networking apps to reach youth and young adults who prefer these modes of communication over more traditional channels that are unaware of their HIV diagnosis and link them to testing.
Successful Linkage to Care	Adaptation of ARTAS for delivery via text messaging with a focus on linking HIV+ individuals into care.

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HIV Care Continuum Domains	Wellness Web Strategy
Support Engagement in Care; Retention in Care	Mobile Wellness delivers 12 weeks of programmed text messages, adapted from UCARE4LIFE, addresses medication adherence, finding social support, risk reduction, etc. Mobile Wellness provides text messages and traditional support to navigate care systems, address other behavioral/mental health needs, and meet basic needs.
Medical Adherence; Viral Suppression	Mobile Wellness delivers 12 weeks of programmed text messages, adapted from UCARE4LIFE, addresses medication adherence, finding social support, risk reduction, etc. Mobile Wellness ensures individuals are adherent to treatment and addresses “fall-outs” or barriers to treatment adherence early to minimize impact on health outcomes.

Effectiveness for this intervention was tested on 118 HIV positive youth and young adults between the ages of 13 and 34, who met one of the following criteria:

- Tested positive for HIV for the first time within the last 12 months
- Aware of their HIV positive status but have never engaged in HIV care
- Diagnosed with HIV more than 12 months ago, but has a gap in care greater than 6 months, within the last 24 months
- Has a viral load greater than or equal to 200 copies/mL at last lab test

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Intervention Description

Wellness Web is a text message-based intervention that supports linkage and retention in care. Wellness Web is made up of several components including 1) adaptation of the evidence-based intervention ARTAS, 2) Mobile Wellness health education text messages medication reminder and appointment reminders, and 3) HIV healthcare navigation services. The goal of the program is to improve clients' self-efficacy through education and skills mastery for managing their HIV health care.

1) ARTAS Adaptation

Anti-Retroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention with the goal of linking recently diagnosed persons with HIV to medical care soon after receiving their positive test result (CDC, 2015). In the first ARTAS study, there was a higher proportion of successful linkage to medical care among the intervention participants (78%) than the standard of care participants (60%) within 6 months. In the ARTAS-II study, 79% of the participants (497 out of 626) attended at least one HIV medical care appointment in the first 6 months of enrollment. (CDC, 2015)

ARTAS consists of up to five client sessions conducted over a 90-day period or until the client links to medical care – whichever comes first. ARTAS views the community as a resource for the client and client sessions are encouraged to take place in-person, wherever the client feels most comfortable. Sessions focus on building rapport, identifying the clients' strengths, and facilitating the clients' ability to achieve health care goals. ARTAS sessions are outlined as follows:

- The 1st session will consist of building a trusting, effective relationship between the client and intervention staff, and identifying the client's strengths, needs, and barriers to accessing care.
- The 2nd and 3rd sessions will focus primarily on goal-setting and identifying client's strengths.
- The 4th session will consist of reviewing progress made in the previous sessions, while continuing to emphasize the client's strengths.
- The 5th session may involve accompanying the client to their medical appointment or transition activities if the client linked to medical care.

The Wellness Web adaptation of ARTAS adheres to the same core elements and session workflows; however, ARTAS sessions occur via text messaging and are delivered to HIV positive individuals re-entering care as well as those who are newly diagnosed. The anticipated differences in delivering ARTAS through text message would be the lack of human presence, conversation styles, and conversation lengths.

2) Mobile Wellness

Clients who are currently linked to medical care, either upon enrollment or completion of the ARTAS adaptation, will be enrolled in 12-weeks of health education text messages to support retention in care. Mobile Wellness text messages are based on the text message library developed by Health Resources and Services Administration's UCARE4Life research study (HRSA, 2016). The UCARE4Life library

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addresses multiple topics including HIV health literacy, risk reduction and medication adherence (HRSA, 2016).

3) HIV Navigation Services

As a text messaging program, Wellness Web provides participants with the convenience to receive help navigating case management and health care services outside of mobile ARTAS sessions. At least one member of the Wellness Web staff is on-call to answer clients' questions as they arise seven days a week from 8:30am until 12:30am. This flexibility provides clients with just-in-time support that facilitates linkage and retention in care.

Intervention Approach / Theoretical Framework

To maintain fidelity with the original design of ARTAS, Wellness Web is based on the theoretical framework of the Strengths-Based Case Management (SBCM) model, Social Cognitive Theory and Motivational Interviewing. The three defining features of the intervention established by these theories are: (1) building effective, working relationships between the client and intervention staff; (2) focusing on the client's strengths rather than weaknesses; and (3) maintaining a client-driven approach.

Social Cognitive Theory. Behavior change is not simple, and many factors affect a person's ability to change. Social Cognitive Theory considers that behavior is a continuous, reciprocal interaction between personal (attitudes and beliefs), behavioral, and environmental influences (Bandura, 1994). Reciprocal determinism explains the interaction and relationship between the person, the person's behavior, and the person's environment. Hence, one's environment can influence behavior, but behavior can also influence one's environment. Social Cognitive Theory assumes people are capable of re-evaluating their behavior, the impact of that behavior on their environment, and the impact of the environment on them and on their behavior (Bandura, 1994). According to Social Cognitive Theory, successful behavior change can be achieved by:

- Learning new information from others
- Discussing strategies with others
- Having guided practice or rehearsal of new behaviors and skills
- Receiving corrective feedback on one's performance of the new behaviors or skills
- Acquiring personal experience with new behaviors and skills
- Receiving social support for the new behavior
- Hearing the positive outcomes of other people who adapted the new behaviors
- Observing new behaviors being modeled
- Observing other people's behaviors and experiences

Strengths-Based Case Management Model. The strengths-based model perspective holds that individuals possess abilities and inner resources that allow them to cope effectively with the challenges of living (Brun & Rapp, 2001). The strengths-based model is client-centered and enhances strengths

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already present in the client. Focusing on self-direction allows clients to retain control of their lives and activate personal strengths to overcome current and future barriers (Brun & Rapp, 2001).

Motivational Interviewing. Motivational interviewing is a client-centered counseling style that enhances readiness for change by helping clients explore and resolve ambivalence (Miller and Rollnick, 1991). Motivational interviewing meets clients where they are at in the stages of change and elicits clients' intrinsic motivations to change and move along through the stages of pre-contemplation, contemplation, preparation and action.

Target Population

Wellness Web is primarily designed for clients, aged 13-34 years old, who are newly diagnosed or re-entering care. Such clients would be able to engage in the full program and benefit from the positive momentum built up from the beginning of the intervention where they receive social support to process an HIV-positive diagnosis and overcome barriers to care, until the end of the intervention where clients' self-efficacy is supported through continued education and reminders. Clients who are eligible for enrollment because they have a previous gap in care or are not virally suppressed, but are currently linked to care, are ineligible to receive the first component of the intervention (mobile ARTAS adaptation) and will be enrolled directly into the Mobile Wellness portion of the intervention with ability to seek navigation services. While only receiving a portion of the intervention, these individuals may still benefit from the health education messages, appointment reminders, medication reminders, and navigation services.

Intervention Typology

The intervention typology chart provides a visual outline of the target population, eligibility criteria, technology utilized, and a portion of our evaluation measures. A brief summary of information covered thus far is also provided.

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Wellness Web 2.0, Coastal Bend Wellness Foundation (Corpus Christi, TX)

Program Summary	Social Media Intervention Overview	Evaluation Summary
<p><u>Target Population</u> Age: 13-34 Gender: Male & Female Race/Ethnicity: All (primarily Hispanic) Sexual Orientation: MSM & Heterosexual Sample Size: 100 Language: English & Spanish Setting: Clinic, community setting</p> <p><u>Inclusion Criteria</u> Unaware of HIV status: Yes Newly Diagnosed: Yes Not linked/engaged in care: Yes Not retained in care/ Out of care: Yes Not adherent to HIV medication: Yes Not virally suppressed: Yes</p>	<p><u>Intervention type</u> Adapted from prior intervention Adjunct to existing services</p> <p><u>Technology Platforms Used</u> Facebook: Yes Social Media: Twitter, Instagram Social Networking Sites/Apps: Yes Text Messaging: Yes, automated + live Website: Yes, mobile optimized</p> <p><u>Functions</u> Communication: Yes Education: Yes – HIV+ healthy living, Rx adherence, retention in care, sexual health, risk reduction, social support, healthy relationships Information: Yes Reminders General: Yes Medical appointments: Yes Medication adherence: Yes Self-monitoring /tracking: No Skills building: Yes Social support/networking: Yes</p>	<p>Evaluation Comparison Group – No</p> <p><u>HIV Health Outcome Measures</u> Increase HIV testing: Yes Improve linkage & engagement in care: Yes Improve retention in care: Yes Improve medication adherence: Yes Improve viral suppression: Yes Improve utilization of support services: Yes Improve health literacy: Yes</p> <p><u>Other Ryan White Part Funding</u> Parts B, D, F</p>

Target population & inclusion summary. Eligibility criteria for the Wellness Web 2.0 intervention included youth and young adults living with HIV between the ages of 13-34, who met one of the following additional criteria:

- Tested positive for HIV for the first time within the last 12 months
- Aware of their HIV positive status but have never engaged in HIV care
- Diagnosed with HIV more than 12 months ago, but has a gap in care greater than 6 months, within the last 24 months
- Has a viral load greater than or equal to 200 copies/mL at last lab test

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Eligibility criteria did not include specific genders, race/ethnicity or sexual orientations. Thus, both males and females of all races and sexual orientations were enrolled. However, due to the demographics of the South Texas population and the disparities that make certain populations more vulnerable to HIV, the majority of enrolled participants were Hispanic men with male sex partners. Enrolled participants demographics are discussed in more detail in the “Outcomes” section of this document.

Intervention type. Wellness Web 2.0 is a text message adaptation of the evidence-based intervention ARTAS. Wellness Web 2.0 is provided as an ancillary service to existing Ryan White case management programs and clinic providing HIV health care services.

Technology platforms used. Wellness Web 2.0 uses social media (Facebook, Twitter and Instagram) and social networking apps (Grindr, Growlr, Scruff, Jack’d, and Adam4Adam) to promote status awareness and conduct outreach and recruitment for the intervention. Text messaging was the main mode of communication for intervention delivery; however, follow-up contact with clients through Facebook was sometimes necessary due to phone service issues. Text message communication consisted of live, one-to-one communication between staff and participants during mobile ARTAS sessions, and automated, push messaging for Mobile Wellness and reminders.

Functions. The mobile adaptation of ARTAS utilizes two-way, text message communication between the client and intervention staff to provides clients with social support and assistance with skills building in order to improve clients’ self-efficacy to manage their healthcare independently. In addition, text messaging allows clients to receive navigation assistance. The Mobile Wellness portion of the intervention uses one-way, push text messages to send clients educational content that supports engagement and retention in care. Mobile Wellness health education text messages address the following topics: HIV 101, finding social support, taking HIV medications, alcohol abuse, substance abuse, mental health, life skills, partner communication, risk reduction for sexual health, oral health and getting check-ups. Finally, Wellness Web 2.0 provides clients with automated, text message appointment and medication reminders.

Evaluation summary & HIV health outcome measures. Wellness Web 2.0 aimed to increase HIV testing through its outreach and recruitment campaigns encouraging individuals to know their status and link to medical care early. Once participants were enrolled, the components of Wellness Web 2.0 supported individual linkage, engagement and retention in care. Progress towards these outcomes was monitored through medical chart data which tracked participant support service utilization, medical appointment visits, and lab values over the course of 6-18 months. Wellness Web 2.0 did not utilize a control group for evaluation comparison purposes.

Intervention Core Elements

The core elements of Wellness Web including 1) adaptation of the evidence-based intervention ARTAS, 2) Mobile Wellness health-based text messages, and 3) HIV healthcare navigation services are essential to maintain program outcomes to improve clients’ self-efficacy through education and skills mastery for the purpose of managing their HIV health care.

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Wellness Web maintains all core elements as originally outlined in the ARTAS implementation manual. The four core elements below are derived from the behavioral change theories described in previous sections and are thought to be responsible for its effectiveness. ARTAS core elements have not been altered in any way and should be adhered to in order to ensure fidelity to the intervention.

1. Build an effective, working relationship between the intervention staff and each client.
2. Focus on the client's strengths by encouraging each client to identify and use his/her strengths, abilities, and skills to link to medical care and accomplish other goals
3. Facilitate the client's ability to:
 - a. Identify and pursue his/her own goals
 - b. Develop a step-by-step plan to accomplish those goals
4. Maintain a client-driven approach by:
 - a. Conducting between one and five structured sessions with each client
 - b. Conducting active, community-based case management by meeting each client in his/her environment
 - c. Coordinating and linking each client to available community resources, both formal (e.g., housing agencies, food banks) and informal (e.g., friends, support groups, spiritual groups) based on each client's needs
 - d. Advocating on each client's behalf, as needed, to link him/her to medical care and/or other needed services

Adaptable Key Characteristics

The Implementation Manual for the original ARTAS evidence-based intervention mentions some adaptable key characteristics of the intervention are:

- Providing transportation to and from medical appointment. This can be in the form of a taxi or public transportation reimbursement or transportation in the intervention staff's personal vehicle.
- Providing incentives such as gift cards or food vouchers for completing ARTAS sessions or evaluation forms.
- Attending medical and other appointments with the client if requested.

In addition to the adaptable characteristics provided in the ARTAS Implementation Manual, adaptable characteristics of the Wellness Web 2.0 intervention include:

- Outreach and recruitment strategies, including the choice of social media platforms and social networking apps used to deliver campaigns.
- The selection of which text-messaging platform used to communicate with clients for mobile ARTAS sessions and delivery of Mobile Wellness health education messages. It is recommended that whichever platform is selected be HIPAA compliant, provide live communication options, and message scheduling features.

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- The timing, sequence and content of Mobile Wellness health education messages. It is recommended that these messages be tailored to fit the culture and health needs of different target populations.
- Staff structure and case load per intervention staff member. Depending on site and community needs, different implementation sites may benefit from having a larger intervention staff team with smaller caseloads per intervention staff member.
- Staff scheduling to address text messages sent by clients after hours. While Wellness Web 2.0 staff members had a rotating on-call schedule to answer clients' questions after hours, this may not be feasible or necessary for other implementation sites.
- Providing free phones and services plans to participants who do not own a working phone at time of enrollment. Different implementation sites may not have the budget to purchase phones for clients and may need to consider limiting enrollment only to those clients with a working phone and service plan.

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Implementation

The process to develop a social media initiative targeting youth and young adults takes much consideration into the target population’s challenges and barriers, the amount of resources and time needed to prepare the organization and staff to adapt and deliver the intervention.

Pre-Implementation Activities

In order to prepare for the execution of Wellness Web, CBWF started with expanding our capacity to implement and sustain social media efforts by assigning key personnel to oversee implementation activities, hiring evaluation staff to assist with data collection, and hiring direct intervention staff.

The work plan for integration of key staff, personnel, and contractors are outlined as followed:

ACTION STEPS	RESPONSIBLE STAFF	RESOURCES & MATERIALS	LOCATION	TIME FRAME FOR COMPLETION
Assign Project Director (PD).	Principal Investigator (PI)/Chief Executive Director	Internal Agency Hiring Process	CBWF	Within first two weeks of contract start date
Recruit, Hire, and Assign a Social Media Coordinator/Project Coordinator position.	Principal Investigator	Job Description; Internal Agency Hiring Process	CBWF; Online Job Recruiting Website	Within first 30 days of contract start date
Formally assign in-house staff to Data Manager.	Principal Investigator; Project Director	Job Description; Internal Agency Hiring Process	CBWF	Within the first 60 days of contract start date
Recruit & hire two Social Media Specialist (SMS).	Principal Investigator; Project Director	Job Description; Internal & External Job Postings; Internal Agency Hiring Process	CBWF; Online Job Recruiting Website	Within the first 60 days of contract start date
Formalize Evaluator & Sub-Contractor agreements.	Principal Investigator; Project Director	Sub-Contractor Agreement & Monitoring	CBWF San Antonio Laredo	Within first 90 days of contract start date

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Intervention Documentation. For the purposes of implementing this type of intervention, there was a need to develop appropriate documentation and instruments for the collection of client-level data taking into consideration to protection of privacy, confidentiality, and human subject's research protection. Because of the potential for disclosure of protected health information (PHI), CBWF developed client-level data collection instruments, informed consents and other related material for submission to our Institutional Review Board for review and approval. When considering an IRB for this type of intervention, timeframe for approval, and budget to spend, it was important to select the most appropriate and efficient institutional review board. After researching and evaluating available IRBs, CBWF utilized Chesapeake IRB, an independent institutional review board located in Maryland. Chesapeake IRB is a member of the executive board of the Consortium of Independent Review Boards, received full AAHRPP accreditation, is registered with OHRP and FDA, and is in compliance with all federal regulations. CBWF determined this IRB worked on a bi-weekly schedule with a turnaround following a meeting of 2 business days, so prompt approval after submission would be received. CBWF contracted Chesapeake IRB's services to oversee the protection of participants' rights and welfare at the local and multi-site level. The Principal Investigator, Project Director, and Evaluator were responsible for the selection of which IRB service to contract and for the submission of documents for approval. Key personnel-initiated request for IRB approval of data collection forms and instruments within 30 days of finalization of materials. The following documentation and instruments were developed for client-level data collection:

- Informed Consent and Research Authorization Form – Adult
- Informed Consent and Research Authorization Form - Parent/Legal Guardian
- Minor Assent Form
- Spanish Informed Consent and Research Authorization Form-Legal Guardian
- Spanish Informed Consent and Research Authorization Form-Adult
- Spanish Minor Assent Form

Participant privacy and confidentiality protection is an utmost importance for the implementation of a social media intervention. CBWF created a detailed Participant Protection Plan (PPP) based on the federal guidelines. This Participant Protection Plan aims at protecting all clients and staff from potential risks; ensures a fair selection of participants and the absence of coercion; identifies data collection procedures, sources, and instruments; maintains privacy and confidentiality; and ensures adequate consent procedures are followed. The CBWF participant protection plan includes procedures for the de-identification of PHI process and the safeguard of the electronic and physical protection of participant data.

Community Assessment. The Coastal Bend Wellness Foundation (CBWF), under the Wellness Web 2.0 initiative, conducted a community needs assessment to better understand patterns and trends of social media use among youth and young adults (ages 13-24) in their service area: Corpus Christi, TX. CBWF used a 38-item questionnaire which was developed with the input of CBWF staff and external evaluators of Wellness Web 2.0. The survey was piloted with ten individuals who were representative of the target

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population to test relevancy and clarity of the questions and to test the software selected for administration. CBWF selected QuickTapSurvey.com as the software for development, administration, and data collection (see Appendix 4 for a sample of QuickTap survey screens). The annual subscription cost for 4 device licenses is approximately \$1900.00. Because of the piloting phase, four questions were changed for wording, two were changed for the options available, and three skip patterns were revised. (See Appendix 4 for a list of survey questions). The survey was administered face-to-face via utilization of iPads; administrators introduced the survey to individuals and either handed the iPad for completion or read the questions to individuals and selected the person's response. Sites within the targeted geographic area were strategically selected to ensure youth and young adults at risk were reached. All of these places have been identified by the outreach team as places where high-risk youth and young adults congregate. A total of 161 surveys were completed between December 10, 2015 and January 21, 2016. Data was collected by CBWF staff.

Data was automatically stored by the selected software and was retrieved by the evaluator in an Excel format. Quality assurance efforts included reviewing each response for accuracy and consistency before analyses. Seven surveys were taken out of the sample due to incorrect date of birth entered or collected and inability to determine correct age at the time of survey completion; leaving a total of 154. (See Appendix 4 for full assessment and results).

Technology Infrastructure. In order to implement a social media intervention like Wellness Web, it is important to assess current internal technology infrastructures to evaluate the capacity of current programs, software, etc. Computers should have the ability to access the internet for research on health-related topics and social media websites (i.e. Facebook, Twitter, Instagram, etc.) for the delivery of campaigns, outreach, and recruitment. Design software such as Adobe Photoshop, Illustrator, InDesign, and Stock are needed for the creation of marketing and promotional materials. Annual subscriptions to Adobe Software is approximately \$650.00 per staff. Tablets, such as iPads, are needed for the engagement and recruitment of target population through internet outreach on social media sites and social networking apps.

Technology Development. Wellness Web looked to purchase a patient communication platform with text messaging capabilities to increase client engagement and retention in HIV care. The platform should have two-way, interactive messaging features which allow Social Media Specialists to deliver the mobile adaptation of ARTAS, as well as send automated, push text messages. CBWF chose to contract with Wellpass for the implementation of the Wellness Web intervention.

Wellpass is a HIPAA-compliant integrated health communications and engagement platform that includes features which allow staff to communicate and engage with patients. This flexible, secure messaging platform allows organizations to have live, one-to-one text-messaging conversations with patients, enroll patients in clinically validated health education programs addressing various health topics, create customized health education programs, and access data about patient use of the

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platform. The platform's interactive messages are delivered to patients through SMS text messages or via a secure messaging mobile app.

The Wellpass Platform includes the following "Platform Features":

- a. The Wellpass portal is a secure web-based interface that intervention staff use to access the platform features. The Wellpass Portal provides the following: Enrollment of Members/Patients in health education programs, access to Member/Patient responses, management of health education programs and messages, Member/Patient consent and enrollment status, staff activity and tools for data access and reporting about use of the platform. Data can also be extracted from the platform for further analysis or integration in other systems.
- b. The "Messaging Campaign Builder" allows CBWF to develop and deploy customized messaging campaigns with automated responses. These campaigns can be targeted to all members enrolled into Mobile Wellness intervention and can be used to support things like welcome scripts, health assessments, incentive program notifications, gap-in-care alerts, administrative messages, marketing messages, re-determination reminders, etc. Campaigns implemented with this feature can also be used to inform and direct Members/Patients to benefits and services.
- c. The "Person-to-Person Messaging Tool" provides CBWF with a web interface that allows staff to hold chat sessions in real-time or asynchronously with Members/Patients (initiated by the Member/Patient or CBWF). ARTAS is delivered in these chat sessions which can take place through text messaging and/or the secure messaging delivered to the Wellpass Mobile App. Sessions can begin on text and be transferred to one of the other interfaces if the CBWF representative determines that the session should be encrypted.
- d. "Health Program Builder" is a scripting tool that allows CBWF to create entirely customized health messaging programs. These programs may be comprised of SMS-based or secure messages and may be automated and interactive. For example, CBWF used the Health Program Builder to create a clinical program focused on a retention and adherence.
- e. The "Program Template Library" is a series of over 20 individual content templates focusing on health conditions such as hypertension or weight loss. CBWF utilized the Program Template Library to modify the HRSA UCARE4LIFE Text Messaging Library and implement it as Mobile Wellness to address specific health outcomes in the South Texas community. These templates were made available in English and Spanish and customized to support specific goals.
- f. The "Wellpass Mobile App" is a downloadable app that provides users with a number of "Standard App Features" that include a secure messaging interface and access to Wellpass Health Programs. The Wellpass Mobile App provides secure messaging to clients enrolled in Mobile Wellness.

Staffing Roles

During pre-implementation discussions, it was critical to identify the different types of roles and responsibilities for staff overseeing and delivering the social media intervention. It is important to have all staff in designated roles within the first 60 days of start date in order to ensure timely execution of

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pre-implementation and intervention activities (See Appendix 1 for Description and Recruitment). The key staffing roles needed for Wellness Web 2.0 are outlined as followed:

1. **Project Director:** The Project Director is responsible for the management and oversight of all programmatic activities through pre-implementation and implementation. The Project Director is responsible for the day-to-day operations of the project to include supervision of staff, management of contracts and sub-contractors, and adherence to HRSA’s reporting requirements. Other duties of the Project Director include the development and/or over-site of the necessary infrastructure development that include development of clinical policy and procedures, QA plan, and planning, implementation and evaluation of work-plan. The Project Director will also be responsible to assure that all measures are met while providing oversight of project fidelity.
2. **Project Coordinator:** The Project Coordinator/Social Media Coordinator is responsible for developing and overseeing the execution of strategic social media and digital initiatives, including developing and managing marketing outreach and recruitment campaigns. The Project Coordinator/Social Media Coordinator will monitor and analyze all social media trends and their impact towards program recruitment goals. This position also provides supervision of intervention staff and monitors grant performance measures as well as prepares progress and performance reports. The Project Coordinator provides oversight and quality assurance in the delivery of the mobile adaptation of ARTAS and Mobile Wellness.
3. **Two Social Media Specialists:** The Social Media Specialists works closely with the Project Director and Project Coordinator to plan and implement targeted social media messages as well as daily engagement with social media platforms to assist with reaching program recruitment goals. The Social Media Specialists are responsible for the delivery of the mobile adaptation of ARTAS and the Mobile Wellness health education messages.
4. **Data Manager:** The Data Entry Manager is responsible for all data collection, entry and management. This position is responsible for the set-up, administration, and completion of client-level multi-site evaluation surveys. The Data Entry Manager’s role is also to perform quality assurance and monitoring of data collection throughout intervention.

Key Staff Attributes

The qualifications necessary to fulfill each role is based on the level of management, oversight, and execution of intervention activities (See Appendix 1 for Description and Recruitment). The education, experience, skill and attributes required to perform the job roles are outlined as followed:

STAFF ROLE	QUALIFICATIONS	SKILLS	ATTRIBUTES
Project Director	<ul style="list-style-type: none"> • Minimum of 4+ years in HIV/AIDS prevention/outreach services with a minimum of 2 years in a management role 	<ul style="list-style-type: none"> • Demonstrated experience and a passion for the social technology universe (i.e. Facebook, Twitter, YouTube, Blogs, Wikis, etc.) 	<ul style="list-style-type: none"> • Organized, the ability to be self-starter and manage staff • Provide training and guidance to

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STAFF ROLE	QUALIFICATIONS	SKILLS	ATTRIBUTES
	<ul style="list-style-type: none"> Bachelor’s Degree, Master’s Degree preferred, in Public Health, Counseling, Social Work or associated field required; in lieu of this requirement, a degree (or partial completion) in similar field(s) together with applicable related experience acceptable. 	<ul style="list-style-type: none"> In-depth knowledge and understanding of social media platforms and their respective participants and how they can be deployed in different scenarios Solid understanding of analytics, SEO and social media platforms and monitoring tools Experience writing, editing and crafting content for the social media space, reporting, and proposals. Experience in the development, implementation, and evaluation of community health initiatives, preferably in HIV or other communicable diseases or sexual health topics. 	<p>staff, work with limited supervision.</p>
<p>Project Coordinator</p>	<ul style="list-style-type: none"> Minimum of 2+ years in social media and digital management experience Bachelor’s Degree, Master’s Degree preferred, in Marketing, Journalism, or associated field required; in lieu of this requirement, a degree (or partial completion) in similar field(s) together with applicable related experience acceptable. 	<ul style="list-style-type: none"> Demonstrated experience and a passion for the social technology universe (i.e. Facebook, Twitter, YouTube, Blogs, Wikis, etc.) Proven ability to run paid ad placements and sponsored content across social media platforms, Facebook, LinkedIn, Twitter, YouTube, etc. and monitor for ROI In-depth knowledge and understanding of social media platforms and their respective participants and 	<ul style="list-style-type: none"> Organized, the ability to be self-starter and manage staff Provide training and guidance to staff, work with limited supervision.

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STAFF ROLE	QUALIFICATIONS	SKILLS	ATTRIBUTES
		<p>how they can be deployed in different scenarios</p> <ul style="list-style-type: none"> • Solid understanding of analytics, SEO and social media platforms and monitoring tools • Ability to use Excel for ROI analysis and reporting • Experience writing, editing and crafting content for the social media space. 	
<p>Social Media Specialist</p>	<ul style="list-style-type: none"> • Minimum of 2+ years of successful delivery of outreach activities and/or community engagement related to health, social marketing, or volunteer initiatives • Bachelor’s Degree in Marketing, Journalism, Social Sciences or associated field required; in lieu of this requirement, a degree (or partial completion) in similar field(s) together with applicable related experience may be acceptable. 	<ul style="list-style-type: none"> • Knowledge of social networking channels and functions/activities associated with each platform • Knowledge and understanding of cultural difference of focus populations • Wide range of community connections • Experience in planning community wide activities, such as awareness and education events • Strong verbal and written communication skills • Experience writing, editing and crafting content for the social media space • Knows how to leverage different social media platforms for informal and formal advertising • Ability to think creatively and develop marketing/guerilla marketing strategies using 	<ul style="list-style-type: none"> • Organized, the ability to be self-starter, meet deadlines and submit artwork to promote events • Maintain positive relationships with other staff, as well as work with limited supervision. • Experience working with Adobe Creative Cloud Software – Photoshop, Illustrator, InDesign • Attention to detail • Organized and can meet deadlines and submit artwork to promote events

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STAFF ROLE	QUALIFICATIONS	SKILLS	ATTRIBUTES
		<p>non-traditional mediums, like hook-up apps</p>	<ul style="list-style-type: none"> • Comfortable approaching members of the community to discuss services available, surveys, etc.
<p>Data Manager</p>	<ul style="list-style-type: none"> • Minimum 2+ years in data collection, entry, and management • Bachelor’s Degree, Master’s Degree preferred, in Information Systems, Business Administration, or associated field required; in lieu of this requirement, a degree (or partial completion) in similar field(s) together with applicable related experience may be acceptable. 	<ul style="list-style-type: none"> • Experience in working with Electronic Health Records • Proficient with PC computers and Microsoft Office applications (including Outlook, Word, Excel) • Previous experience completing data extraction from medical charts. • Previous experience with database maintenance. • Ability to think critically and develop innovative ways to effectively manage large volumes of data. • Experience entering data into ARIES or other electronic systems for Ryan White Services Report (RSR) • Experience Generating and submitting reports to funding sources • Knowledge of working with funding sources and agency management team to identify and rectify any issues with data management, tracking, and/or quality assurance. 	<ul style="list-style-type: none"> • Self-motivated, adaptable, takes initiative and detail oriented. • Ability to function independently and as a part of a team. • Strong interpersonal and leadership skills. • Organized, the ability to be self-starter. • Maintain positive relationships with other staff, as well as work with limited supervision.

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Training

In order to ensure proper delivery of the Wellness Web intervention, staff should be trained on the original ARTAS evidence-based intervention, Wellness Web adapted intervention, HIV Navigation Services model and Motivational interviewing. Additional trainings can be provided to improve staffs' practical and soft skills as they relate to HIV healthcare and diverse populations.

ARTAS Training. ARTAS is a 2-day training hosted by the CDC that prepares staff to deliver the ARTAS intervention directly to clients. Because ARTAS is the core component of the Wellness Web intervention, this training is required to be completed by all Wellness Web staff within in three months of hire. After attending this training, intervention staff should understand strengths-based case management, facilitate clients' ability to create an action plan for being linked to medical care, and identify strategies for adapting ARTAS to be delivered through mobile communication.

Wellness Web Training. Wellness Web training is a 2-day training that is specific to the intervention and not publicly available. The project's Local Evaluator, Project Director and Project Coordinator host this training onsite. A guide for facilitating Wellness Web training is provided in the Appendices. Intervention staff should complete this training within three months of hire. Wellness Web training covers protocols for outreach and recruitment, screening, enrollment, delivery of intervention, how to use technology involved in intervention delivery and record keeping. This training emphasizes the importance of adhering to ARTAS core elements while still adapting sessions to be delivered through text message. After this training, intervention staff should be able to deliver client-centered support following Wellness Web's strict timeline for delivering intervention components to participants.

HIV Navigation Services. HIV Navigation Services (HNS) is a 2-day training hosted by the CDC that is designed to improve navigation skills for those delivering prevention services to people living with HIV and high-risk HIV negative individuals (Bradford, 2006). After attending this training, staff should be able to explain how navigation services help people living with HIV obtain better health outcomes, describe how navigation services support a client through the HIV Continuum of Care, and integrate HNS skills into the delivery of the mobile ARTAS adaptation. Wellness Web staff should complete this training within 3 months of hire.

Motivational Interviewing 101 and 201. Motivational Interviewing 101 and 201 are 1-day trainings hosted by Texas HIV Connection. These trainings provide staff with skills to engage with clients and receive information about their personal lives, including barriers to care and motivations related to behavior change. Staff also learn how to help clients set goals and carry out change talk. This training reinforces client-centered skills learned during ARTAS. Wellness Web staff should complete these trainings within 3 months of hire.

Optional Trainings. Organizations implementing Wellness Web may provide staff with additional trainings to increase staffs' knowledge about HIV, issues that affect high-risk communities, working with diverse populations and practical skills to be used during outreach settings. Examples of such trainings

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would be Texas Foundations of HIV Testing and Counseling, Opioid Overdose Awareness Training, Cultural Competency and First Aid/CPR.

Youth Advisory Boards

The Coastal Bend Wellness Foundation (CBWF) collaborated with two youth organizations, Youth Network Out Together (YNOT) and the South Texas Teen Leadership and Development (STTLD), during the pre-implementation and implementation phases of the intervention. Youth and young adults who participated in these organizations provided insight about young adults' awareness of how HIV affects their peers, need for programs that assist with accessing health care, and opinions on program marketing materials.

The Coastal Bend Wellness Foundation's YNOT program provides social support for LGBTQ+ youth and young adults between the ages of 13 and 24. YNOT provides a safe space for LGBT youth to discuss issues pertinent to them. YNOT addresses health disparities that affect LGBTQ+ youth and provides access to health care, mental health services and other resources. The organization is made up of a general membership and Youth Advisory Board. YNOT has an average of 10 general members and 5 Youth Advisory Board members. The majority of YNOT members are under the age of 18. Members were not asked to disclose their HIV status.

South Texas Teen Leadership and Development (STTLD) is a program of the Community Action Corporation of South Texas, a non-profit organization dedicated to providing equal healthcare, education, housing and economic opportunities. STTLD addresses topics such as teen pregnancy, STDs and healthy decision-making skills among young adults through the facilitation of classroom discussions and activities. The STTLD program works with middle school and high school students in the mostly rural communities of Alice, Texas and San Diego, Texas. CBWF partnered with STTLD to get feedback on the Wellness Web program from 50 high school students in both Alice and San Diego.

Local Evaluation Survey. During the Pre-Implementation phase, CBWF utilized a Local Evaluation Survey to assess social media usage among youth and young adults throughout its service area. The survey was created on the QuickTap survey app and administered via iPads. Members of YNOT and STTLD provided insight into the types of mobile devices they use, social media apps they access, where they find information, and comfort level discussing health through mobile technology. Results of the survey were used to determine which platforms to use for marketing of the intervention and how to deliver intervention messaging.

Marketing Material Evaluation. Through the QuickTap survey app, members of YNOT and STTLD provided feedback on print and digital marketing materials used during the Pre-Implementation and Implementation phases. Youth evaluated three potential new marketing campaigns once a quarter. The surveys assessed visual appeal, relevancy of imagery and messaging, and quality of the information. Survey participants also provided feedback on how they would improve each campaign. Survey results

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were used to edit imagery and messaging before implementing each campaign (See Appendix 5 Survey and Results).

Group Discussions on HIV Awareness. Members of YNOT and STTLD also participated in one-time group discussions that addressed awareness of HIV in the community, comfort level discussing HIV-related topics, knowledge of HIV healthcare resources, and ideas for improving access to HIV healthcare. CBWF staff, as well as YNOT and STTLD staff, facilitated these group discussions using a questionnaire and discussion guide. Group sizes ranged from 10-20 youth. Group discussions with STTLD members took place in a classroom setting during regular, school-hour STTLD sessions. Group discussions with YNOT members occurred in available meeting space at CBWF during regular weekend meetings. Feedback from group discussions was used to improve messaging and placement/distribution of Wellness Web marketing materials.

Marketing and Social Media

Development of Print and Social Media Marketing Materials. All print and digital Wellness Web marketing materials were created by intervention staff who had educational backgrounds and/or work experience in marketing, communication and/or graphic designs. Staff followed a set of protocols for the development of marketing campaigns, which included:

- **Define call to action and expected outcomes for marketing campaigns.** Examples of expected outcomes would be to increase visits to the Wellness Web page of the CBWF website, increase number of messages sent through the website's Live Chat feature, or increase Facebook page interactions, etc.
- **Define target audience.** Staff defined specific subpopulations within the eligibility criteria that marketing campaigns would be targeted towards. Examples of sub-population targets would be:
 - a. Newly diagnosed youth between the ages of 13-18 with parents who help to coordinate their healthcare.
 - b. Young adults between the ages of 24-34 with a gap in healthcare who work multiple part time jobs while attending school
- **Prepare.** Staff used a Local Evaluation Survey to assess how youth and young adults access health information and utilize social media. Staff evaluated the effectiveness of current marketing efforts to reach the target audience using results and social media analytics from current campaigns. Staff also researched what methods similar agencies were using to reach youth and young adults.
- **Create.** Staff created 3 new marketing campaigns per quarter using Adobe Creative Cloud graphic design software. Campaigns were sized and formatted for social media pages, flyers, postcards and posters.
- **Get Feedback.** Once created, intervention staff received feedback on marketing campaigns from youth and young adults. Images from each campaign were input into a QuickTap survey template that asked questions to evaluate visual appeal, relevancy of imagery and messaging,

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and quality of information. Surveys participants between the ages of 13 and 34 were sought out at organization meetings, community events, and outreach opportunities.

- **Revise and publish.** Marketing campaigns were revised based on feedback that was received through the QuickTap survey and then printed or published online.

Traditional Social Media. At the start of the grant, the Coastal Bend Wellness Foundation had an established social media presence on Facebook, Instagram, and Twitter. During the Pre-Implementation phase, CBWF evaluated previous content strategies for each social media page and decided best methods to use moving forward that would create a digital space where young adults ages 13-34 and their friends or family members felt comfortable learning about HIV health care and the Wellness Web program. Intervention staff developed various online marketing campaigns to promote Wellness Web that fit the agency's revised social media strategy. In order to fit this strategy, marketing campaigns included positive and empowering messaging that would help to de-stigmatize HIV and encourage people to access services. Marketing campaigns were evaluated by members of the target age group and revised before posting to social media sites.

- *CBWF Facebook and Hard Candy Facebook.* Staff posted about Wellness Web to social media pages at least once a week to maintain a constant digital presence. CBWF posted marketing materials to two Facebook pages, a general CBWF agency page that appeals to an audience between the ages of 30-50+ and a Hard Candy page that appeals to an LGBT audience between the ages of 18-30+, on alternate weeks to avoid duplicate postings. In addition, CBWF paid to boost Facebook posts to targeted demographics in order to reach a greater audience than those who were already following the agency's Facebook page. Specifications for target demographics included individuals aged 13 to 50. The age range was expanded beyond the enrollment criteria to increase the likelihood that friends or family members of HIV positive youth and young adults would also see Wellness Web promotions. Although the majority of the CBWF service area is rural, staff were able to geo-target Facebook ads to include the most populated cities and towns to reach the most people.
- *Instagram.* CBWF's Instagram account promotes agency services and provides health education messages, using a unique, behind-the-scenes personal view point. Wellness Web staff used Instagram to provide HIV healthcare information, promote Wellness Web intervention, and familiarize potential clients with Wellness Web staff.
- *Twitter.* CBWF's Twitter account is used to promote agency services and provide health education messages, while giving real time updates about the agency. For the purpose of the intervention, Twitter was used to provide information about HIV healthcare, promote Wellness Web activities and recruit eligible individuals for enrollment.

Social Networking Apps. Internet Outreach through social networking apps such as Grindr, Growlr, Scruff and Jack'd is a proven method for reaching at-risk populations where they are and providing health information. CBWF Outreach staff maintain a presence on these apps to promote HIV testing, risk reduction, and PrEP. Intervention staff created profiles on these apps specifically to share information about HIV healthcare and recruit participants for the Wellness Web program.

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- Grindr has proven to be the most popular and diverse social networking app among young adults in the CBWF service area. Grindr lets users characterize themselves by “tribe.” The 12 tribes include Bear, Clean-Cut, Daddy, Discreet, Geek, Jock, Leather, Otter, Poz, Rugged, Trans and Twink. Based on staffs’ Internet Outreach experiences, Grindr members tend to be younger than members on any of the other apps used for Internet Outreach. Wellness Web purchased a one-time advertisement placement on Grindr that included 3 months of banner ads, pop-up ads, and direct messages to app members’ inboxes. Paid advertisement campaigns were geo-targeted to reach members within a 25-mile radius of pinpointed area. These areas were chosen by analyzing a map of the CBWF service area and choosing locations that would encompass the most populated areas. Unfortunately, corporate changes at Grindr raised the prices of advertising outside the agency’s budget.
- Growlr is the second most popular social networking app in CBWF’s service area. Growlr’s target audience consists mainly “Bears,” which are “masculine gay men who may be hairy, heavy-set or masculine.” Based on observations during Internet Outreach, Growlr users tend to be slightly older than those on Grindr. In addition, Growlr provides advertising options that are more affordable than Grindr. Wellness Web paid for advertising campaigns on Growlr that included banner ads, pop-up ads, and direct messages to app members’ inboxes. Paid advertisement campaigns were geo-targeted to reach members within a 25-mile radius of pinpointed area. These areas were chosen by analyzing a map of the CBWF service area and choosing locations that would encompass the most populated areas. Length of campaigns was usually one to three months based on the availability of funds. Frequency of campaign placements was also determined by the availability of funds.
- Although not as widely used in the Coastal Bend as Grindr and Growlr, Scruff provides a unique feature that allows users to search for other men who are HIV positive. In addition, Scruff provides non-profit organizations with free advertising opportunities through their Benevolads program. Wellness Web maintained 6-month banner ad campaigns on Scruff throughout the intervention.
- Jack’d and Scruff have a similar usage rate among gay men in the Coastal Bend. Based on observations during Internet Outreach, the majority of men on Jack’d are young Hispanic and African American men who, statistically, are at higher risk for acquiring HIV.
- CBWF created an Adam4Adam Health Counselor Profile. Although the members on Adam4Adam tend to be older than the intervention eligibility criteria, Adam4Adam provides a unique option for health organizations to create Health Counselor profiles. These profiles appear on the search grid of Adam4Adam members; however, profiles are noticeably distinguished as Health Counselor profile.

Print Media. CBWF utilized flyers, posters and postcards featuring the designs and messaging that were that were evaluated by members of the target population and used on social media graphics. These print materials were distributed to organizations that may diagnose or provide health care to people living with HIV, including health departments, hospitals, emergency rooms and community health centers. At the locations, intervention staff were able to hang flyers or posters in locations that would

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be visible to clients, including lobbies, waiting rooms, treatment rooms, etc. Postcards were also provided to these locations and placed where clients could easily pick them up and take with them. In addition, these small printer materials were displayed at locations that targeted eligibility age range versus HIV status. Examples of locations that targeted age range include college campuses, coffee shops, bars, and local retail businesses.

Intervention staff also participated in community outreach events where they could engage people in conversations about the program and distribute postcards. Staff held information tables at a health-related events, such as health fairs and annual HIV awareness events, and during scheduled outreach nights at local LGBT bars.

Outdoor Media Campaigns. CBWF also utilized an outdoor advertising campaign that included outdoor boards and bus signage. Outdoor media provides opportunities to reach a greater audience including individuals who may have been missed through in-person outreach or social media opportunities. Long term campaigns build a strong presence in a targeted area achieving greater name recognition through repetitive viewing.

CBWF evaluated a variety of purchasing options when building an outdoor board campaign. Outdoor board options included digital boards, bulletins, street panels and posters. Posters provided the most cost-effective options for geographically and demographically targeting campaigns. Poster locations were concentrated in densely populated urban areas with high street traffic. CBWF chose poster locations that were in close proximity to the point of service or near major roadways that clients travel to reach the point of service. Throughout the life of the grant, CBWF chose to purchase two 1-month poster campaigns and two 3-month poster campaigns. Purchase options were based on available funds per grant fiscal year. Distribution of poster purchases among each Wellness Web community partner was based on an informal assessment of each community and anticipated benefits of building a greater outdoor media presence.

Bus advertising options include exterior side panels, side wraps and entire bus wraps and interior transit cards. Bus signage provides opportunities to reach a diverse audience as signage is placed on bus numbers that regularly change routes. Exterior signage on the passenger side of the bus would be preferred in order to maximize exposure throughout the community versus only those who ride buses. Throughout the life of the grant, CBWF chose to purchase two 3-month interior transit card campaigns that included 10 transit cards each and two 1-month exterior side panel campaigns. Distribution of purchases among each Wellness Web community partner was based on an informal assessment of each community and anticipated benefits of building a greater outdoor media presence.

Outreach and Recruitment

Initial Point of Contact. In order to be proactive, Wellness Web staff provided navigation services to all HIV positive individuals who were seeking HIV case management and health care services at CBWF regardless of eligibility for Wellness Web enrollment. This included both individuals who were referred by other agencies or were seeking services on their own behalf and contacted staff either by phone,

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office walk-in, or chat session through the CBWF Live Chat feature. The procedures described below ensured that intervention staff were able to provide Wellness Web program information to all potentially eligible clients and conduct enrollments in a timely manner.

1. Upon initial contact with clients, intervention staff record client information such name, phone number, address, date of birth, date of HIV diagnosis, healthcare engagement level, and insurance status.
2. Staff use this information to screen clients for Wellness Web eligibility.
3. Regardless of eligibility, intervention staff provide clients with information about paperwork requirements to enroll in Ryan White services and become a new clinic patient. Intervention staff schedule an appointment to meet with the client in-person within 24-48 hours to collect paperwork and further discuss agency processes.
4. If client is eligible for Wellness Web, intervention staff provided client with more information about the program during their in-person meeting. If client is interested in enrolling in the Wellness Web program, intervention staff move forward with the Wellness Web enrollment process during this initial in-person meeting.
5. Once client completes paperwork, staff inform the client that the Case Management Intake Specialist will be calling them within 24-48 hours to schedule a Ryan White intake appointment. If client enrolled in Wellness Web, intervention staff begin delivery of the intervention within 24-48 hours. If client did not enroll in Wellness Web, intervention staff transition client to Case Management Intake Specialist as new point of contact.

This intake process benefitted both Wellness Web eligible and non-eligible clients by making the process of entering HIV health care smoother. This process also ensured that Wellness Web staff did not miss opportunities to provide eligible clients with information about the program and enrollment.

In-Reach. The Coastal Bend Wellness Foundation's in-house clinic and Mobile Health Center provided an opportunity to reach out to HIV positive clients who may be having difficulty attending medical appointments, adhering to medication and/or maintaining a suppressed viral load. Once a quarter, the Project Director collaborated with the Director of Clinical Services to generate a report of HIV positive clients ages 13-34 who were identified as out of care, having had a gap in care greater than 6-months within the past two years, or not virally suppressed. Wellness Web staff used the report for targeted outreach opportunities.

Intervention staff attempted to contact out-of-care clients through phone calls, emails and/or home visits. First, staff made three attempts to call clients at various times of the day over a two-week period. If clients did not respond to phone calls or voice mails, staff sent clients an email. If clients did not respond to the email within two weeks, staff attempted to reach clients during a home visit. If the client was not home at the time staff visited the client's home, staff left a letter in the client's door informing them they were eligible for a new agency program with incentives.

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For clients who were currently connected to care but had a gap in care or were not virally suppressed, Wellness Web staff met with clients during their next case management appointment, labs, or clinic appointment. Clinic or case management staff were notified of these eligible clients via a feature in the agency's scheduling system and were able to facilitate an introduction between the client and Wellness Web staff.

When pitching the Wellness Web program to clients listed on the clinic report, intervention staff had to take into consideration the various levels of health care engagement and unique motivations of each client. Wellness Web staff tailored their recruitment pitch to best address these differences in order to catch the client's attention before diving into a full description of the program. For newly diagnosed clients, this might mean emphasizing confidentiality and not needing to visit an HIV clinic setting to receive social support. For clients who are not virally suppressed, this might mean emphasizing the convenience of scheduled medication reminders.

Internet Outreach. Intervention staff maintained profiles on the social networking apps Grindr, Growlr, Scruff and Jack'd. Staff utilized a passive outreach approach on these apps, waiting for app members to initiate conversations with staff. Occasionally, staff would attempt to peak app members' interest in their profile by "liking" members' profiles. Through these approaches, staff could answer questions about HIV health care and how to access services while reducing the likelihood that their profile would be reported for app misuse. Wellness Web staff were logged in to apps during regularly scheduled office hours, during late night outreach hours, and while on-call for CBWF's Live Chat feature. Regular office hours at CBWF are 8am-5pm, unless staff were scheduled to work an adjusted shift for a late-night outreach event. To reach populations who are more active on social networking sites outside of traditional work hours, staff were scheduled to work late night outreach events tabling at local bars where they could do in-person and internet outreach at the same time. Late night outreach events were scheduled once a week from either 11am – 8pm or 3pm – 12am. Wellness Web staff rotated weekly shifts answering questions on CBWF's Live Chat feature from 8:00am-12:30am. While scheduled to work on-call shifts, staff also remained logged in to their social networking apps to improve availability to meet clients' needs.

Many social networking apps have a distance radius that limits the amount of profiles users can view at a certain location. In order to reach more users, Wellness Web staff travelled twice a month to different cities and counties within the CBWF service area to do Internet Outreach. This strategy was also beneficial for providing easier access to services within rural counties.

Outreach Events. Wellness Web staff participated in outreach events such as HIV awareness events, community events, health fairs, and outreach nights at local LGBT bars. These events provided opportunities for more aggressive outreach. Staff ensured that every person who approached the information table left with Wellness Web promotional materials. In addition, staff were able to walk around events and initiate conversations with those in attendance. Conversations not only included information about the program, but also stressed how many people are directly or indirectly affected by

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HIV and should hold on to program information in case they ever meet someone who needs to access services.

Outreach to Health Organizations. Wellness Web staff contacted other community health centers, testing agencies and hospitals to host “Lunch and Learn” events. During these events, staff presented information about the Wellness Web program, relevancy to the host organization, benefits to their clients and the process of referring clients to Wellness Web. Staff also provided the host organizations with flyers and postcards they could share with co-workers and clients.

Procedures/Protocols

Screening. The Wellness Web screening process involves gathering client information to verify client eligibility. Screenings may take place in a variety of settings including immediately before or after a lab, clinic, or case management appointment, during a home visit, while at an outreach event, or on a phone call. Wellness Web staff will use the Screening Questionnaire to gather the client’s name, age, HIV status, HIV healthcare engagement level, and ability and willingness to access new media. If client meets Wellness Web eligibility criteria, Wellness Web staff will either proceed with enrollment or schedule an enrollment appointment.

Enrollment. During the enrollment process, intervention staff will provide a full explanation of the Wellness Web program and the services that client can expect to receive as a part of the program. Intervention staff will also assist client with filling out required consent forms and paperwork for participation. Staff will determine if client needs and is eligible to receive a free phone to participate in the program. Enrollment ends with ensuring that the client’s information is properly entered into the Wellpass text message platform.

Client Locator Form. Staff will have the client fill out a Client Locator form during the enrollment session. The Client Locator form collects demographic and contact information. The contact information section includes email address, social media profiles, and alternate contacts in case the client becomes difficult to get a hold by phone. Intervention staff explain to clients that all communication is confidential, and no information will ever be shared publicly. Clients are encouraged to provide as much information as possible.

Program Consent Form. Staff will review Program Consent form with the client during the enrollment session. The Program Consent form explains the purpose of the program, confidentiality, and the right to leave the program at any time. This form is to be signed by the client, the intervention staff member who is explaining consent, and impartial witness if applicable. By signing the Program Consent form, the client is agreeing that they are interested and willing to participate in Wellness Web.

Free Phone Eligibility. During the enrollment session, if the client expresses a need for a phone in order to participate in the program, staff will assess if client is eligible to receive a free smartphone and pre-paid service card through the Wellness Web program. Eligibility criteria to receive a phone include not having a phone, not having stable phone service, or client’s current phone belonging to another party

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and client is uncomfortable receiving health care information on that phone. If client is eligible to receive a phone, staff will activate a new phone and provide information about saving phone numbers, sending text messages, deleting messages, and changing text message notification settings.

Wellpass Consent. During the enrollment session, staff will review the Wellpass Mobile Authorization form which explains how the Wellpass platform will be used to send the client unencrypted text messages and automated health messages, medication reminders and appointment reminders. Once the Wellpass Mobile Authorization form is signed, staff will enter client's information into the Wellpass platform and send a text message to confirm the client's phone number. If the client does not wish to receive unencrypted text messages, staff will assist client with downloading the Wellpass messenger app and provide a tutorial with how to use its features. After the client's phone number is confirmed, staff will prompt an automated phone call through Wellpass to finalize consent for use of the platform.

Intervention delivery for clients who are newly diagnosed or re-entering Care. If the client is newly diagnosed or re-entering care, intervention staff will contact the client via text message to initiate first mobile ARTAS session within 24-48 hours of enrollment. During the first mobile ARTAS session, staff will focus on building a relationship with the client, discussing client's potential barriers to health care, and identifying personal strengths and resources client can use to overcome barriers.

If during the first mobile ARTAS session the client mentions they are ready to link to medical care, intervention staff will ensure that the client would be prepared for their appointment with necessary paperwork, list of medications, questions for the doctor, transportation etc. Staff will facilitate scheduling of client's medical appointment with the intake specialist.

If client is not ready to link to medical care, staff will provide mobile ARTAS sessions 2-5 or the number of sessions needed up until client is ready to link to medical care or up to 90-days. During these sessions, staff continue to help the client address barriers to care and identify strengths to achieve healthcare goals. Once the client is ready to link to medical care, intervention staff will facilitate scheduling of client's medical appointment with the intake specialist.

All clients linking to medical care will receive a scheduled appointment reminder that is delivered to the client 24-hours before their appointment. In addition, clients will receive an automated follow-up message asking how their appointment went. If client attended appointment, staff will initiate a mobile ARTAS close out session and prepare the client to be transitioned into Mobile Wellness. If client did not make their medical appointment, they will continue with sessions 2-5. If client completed all 5 mobile ARTAS sessions and still did not link to care, they will be linked with long-term resources to help address remaining barriers.

After the mobile ARTAS close out session, clients will be enrolled in the 12-week Mobile Wellness program that sends automated health education text messages through the Wellpass platform. If the client is interested, staff will schedule medication reminders to be delivered at a frequency determined by the client. Reminders for follow-up medical appointments will also be scheduled.

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Intervention delivery for clients who are currently engaged in care. Clients who are already engaged in medical care, but had a gap in care within the past two years or are not virally suppressed will be directly enrolled into the Mobile Wellness text message program to support medication adherence and retention in care. Intervention staff will also determine if the client is interested in receiving medication reminders. Intervention staff will schedule appointment reminders for upcoming medical appointments.

Monitoring and Evaluation. The Project Coordinator is responsible for monitoring the Social Media Specialists' delivery of the intervention to participants. Each mobile ARTAS session will be reviewed by the Project Coordinator to ensure fidelity to the original ARTAS design is being followed as closely as possible. The Project Coordinator will use the Shadowing Assessment Exercise form utilized in the original ARTAS to help assess fidelity of mobile ARTAS sessions. The Project Coordinator will meet with the Social Media Specialists once a week to review participant progress and provide feedback on improving communication with participants. Additionally, Project Coordinator will review participant feedback provided in the Patient Satisfaction Survey, which is administered upon completion of the intervention, and review with Social Media Specialists to improve program performance.

Partners

In order to successfully implement Wellness Web, it is important to collaborate and partner with organizations, clinics, providers, and other entities that have access to and engage with the target population. CBWF sub-contracted with the Laredo Health Department in Laredo, Texas and the San Antonio AIDS Foundation in San Antonio, Texas to increase enrollment opportunities. Laredo and San Antonio were chosen as collaborators for this program due to the similarity of population demographics, comparative population sizes, positivity rates, and pre-existing partnerships with CBWF. CBWF partnered with local health authority, Corpus Christi-Nueces County Public Health Department, who are responsible for completing partner services and public health follow-up for those diagnosed with HIV. CBWF also partnered with local hospital system, Christus Spohn, who diagnoses and treats many HIV positive individuals on an annual basis.

Staff at each sub-contractor site were designated to assist with sending CBWF intervention staff participant referrals. CBWF intervention staff were responsible for following-up on referrals, traveling to sub-contractor sites to enroll referred participants, delivering the intervention to the client, and collecting follow-up date. Designated staff at each sub-contractor site assisted CBWF staff with the collection of medical chart data used to evaluate the impact of the intervention.

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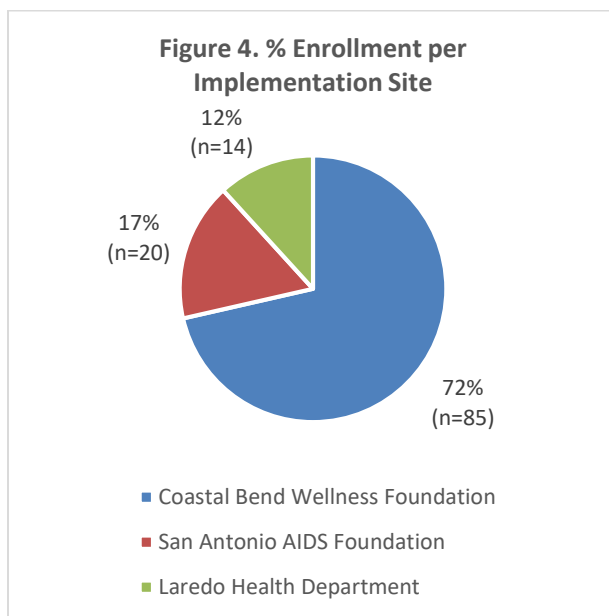
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Program Outcomes

Enrollment Outcomes

A total of 118 participants were enrolled across the three implementation sites with the majority of participants (72%) enrolled at the Coastal Bend Wellness Foundation (Figure 4). Although enrollment was not limited by sex or gender identity, 85.6% of participants identified as cisgender males and 79% of all participants were ages 25-34. Additionally, 53% of participants identified as gay, 22% as straight, and 17% as bisexual.

At the time of enrollment, 33% of clients were identified as newly diagnosed and never linked to care, 12% were identified as newly diagnosed but already linked to care, and 55% were identified as either having a gap in care or not being virally suppressed. In terms of intervention implementation, this means that 33% of enrolled clients were eligible to participate in the mobile adaptation of ARTAS and Mobile Wellness, while 67% were eligible to participate in the Mobile Wellness portion of the intervention only.



Mobile ARTAS Engagement

Participants who were newly diagnosed and never linked to care at the time of enrollment were engaged in the mobile adaptation of ARTAS. Of the 118 participants enrolled, 33% were eligible to participate in mobile ARTAS sessions. Intervention staff attempted to engage all mobile ARTAS eligible clients in at least one mobile ARTAS session before clients linked to medical care. However, of the mobile ARTAS eligible clients, only 55% engaged in at least once mobile ARTAS session. This low engagement rate is due to a small pool of eligible clients as well as challenges engaging clients.

Among participants who engaged in mobile ARTAS sessions, the average number of sessions per client was 2.75 sessions suggesting that the average participant only required one or two ARTAS sessions

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before linking to care and a close out session before starting the Mobile Wellness portion of the intervention. The average mobile ARTAS session length was 3 hours and 45 minutes while the median mobile ARTAS session length was 1 hour and 20 minutes. The range for length of mobile ARTAS sessions was 27 hours and 57 minutes. The differences between the average, median and range in session time frames illustrates how some mobile ARTAS sessions were not continuous, back-and-forth conversations; they occurred over the course of several hours or over the course of an entire day.

The average number of messages sent by intervention staff per mobile ARTAS session was 22 messages while the average number of messages sent per client per mobile ARTAS session was 20 messages indicating that clients are as equally engaged in mobile ARTAS sessions as staff.

**Demographic Characteristics of WellnessWeb
Participants (N=118)**

Characteristic	n	% (n/N)
Gender		
Male	101	85.6%
Female	16	13.6%
Trans	1	0.8%
Age at Enrollment		
Ages 13-17	2	2%
Ages 18-24	23	19%
Ages 25-34	93	79%
Ethnicity		
Hispanic	90	76%
African American	13	11%
White	15	13%
Sexual Orientation		
Straight	26	22%
Gay	63	54%
Queer	5	4%
Bisexual	20	17%
Other	4	3%
HIV Status at Enrollment		
Newly Diagnosed	50	43%
Gap in Care	61	52%
Not Virally Suppressed	4	3%
Never Linked to Care	2	2%

Mobile Wellness Engagement

Participants who were linked to care at the time of enrollment were not engaged in mobile ARTAS sessions and were directly enrolled into Mobile Wellness health education messages. Of the 118 enrolled participants, 56% were enrolled directly into the Mobile Wellness script messages. Newly

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diagnosed clients who were not linked to care at time of enrollment were enrolled in Mobile Wellness messages after linking to medical care and completing a mobile ARTAS close out session. Assuming ideal progression through the intervention, all 118 would have received Mobile Wellness health education messages. However, clients were able to opt-out of receiving Mobile Wellness messages with 7% of participants deciding to do so before they had received all Mobile Wellness messages. Additionally, staff errors and technical glitches in the Wellpass platform which were out of intervention staff control led to an additional 18% of participants only receiving a portion of the Mobile Wellness messages.

Health-Related Outcomes

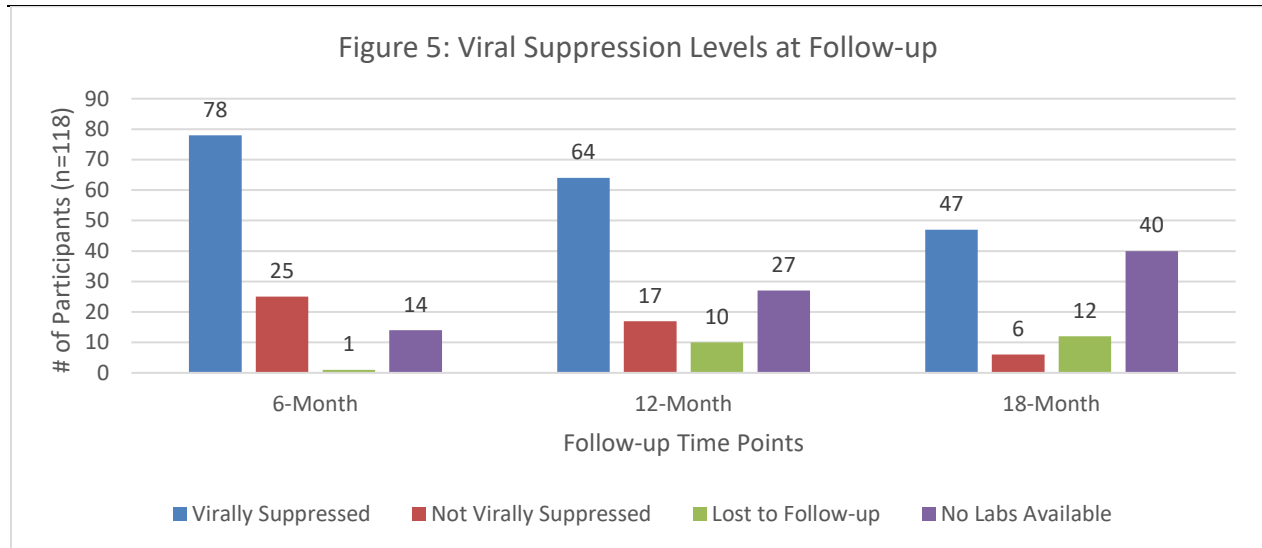
Health-related outcomes such as medical appointment attendance, viral load, and CD4 count were monitored for each participant every 6-months for up to 18-months following enrollment in the intervention. Health-related data were collected via two methods – client self-report through a multi-site evaluation (MSE) survey and medical record review. Anecdotal data from intervention staff indicated that many participants struggled with self-reporting viral load and CD4 counts as a part of the MSE survey. Often, participants were unsure of the difference between their CD4 and viral load and/or did not remember their lab values. As such, when taking the MSE survey, many clients took their best guess when reporting their most recent lab values. For this reason, only health-related outcomes collected from medical chart review are reported in this section.

Linkage to Care. Of all newly diagnosed participants who had not linked to medical care at the time of enrollment, 96% linked to medical care. Of these participants, 100% of those who participated in at least one mobile ARTAS session linked to medical care.

Viral Suppression. Figure 5 shows participant viral suppression levels at the 6-, 12- and 18-month follow-up time points. At the 6-month follow-up point, 69% of participants had a suppressed viral load. By the 18-month time point, 40% of participants had a suppressed viral load. We also see a 22% increase in the number of participants for whom viral load information was not available.

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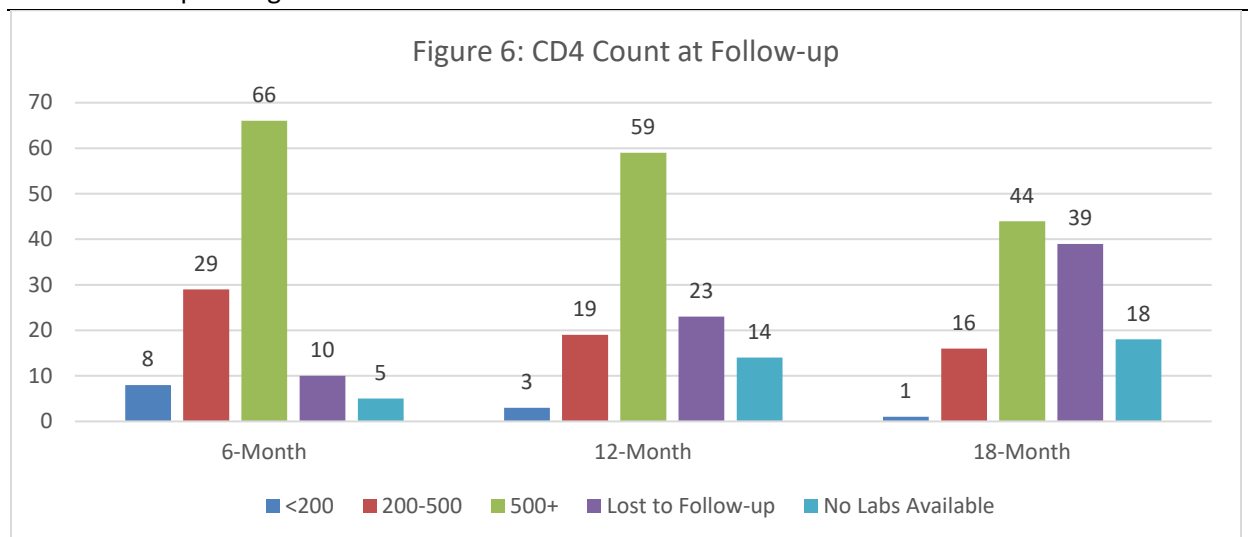
Viral Suppression Level Definitions

- Virally suppressed: viral load < 200 copies/mL
- Not virally suppressed: viral load >200 copies/mL
- Lost to follow-up: participants who moved out of the service area, were incarcerated, left the study, or deceased
- No labs available: participants for whom medical chart data is not available and, to best of intervention staff knowledge, have NOT moved, became incarcerated, passed away, or refused to participate in the study. Participant medical chart data may be unavailable due to time point outside of reporting period (i.e. data collection ended in August 2019, but 18-month follow-up is past this date), difficulty accessing medical chart data from other sites, or client fell out of care, but staff are unable to confirm.

CD4 Count. Figure 5 shows participant CD4 counts at the 6-, 12- and 18-month follow-up time points. At the 6-month follow-up point, 81% of participants had a CD4 count greater than 200 with 56% within the normal CD4 range of 500-1,500. At the 18-month time point, 51% of participants had a CD4 count greater than 200. Between the 6-month and 18-month follow-up, there is a 25% increase in the number of participants for whom labs are not available.

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Statistical Analysis Conducted by the Evaluation and Technical Assistance Center. The Evaluation and Technical Assistance Center (ETAC) for this initiative collected multi-site evaluation survey data and medical chart data from each site and provided evaluation assistance with statistical analysis. Changes in mean changes in HIV care continuum outcomes were evaluated over time (from baseline to 18 months). The following outcomes were analyzed.

Source	Outcome	Response levels
Medical chart data	Viral suppression	1 = < 200 copies/mL; 0 = otherwise
ACASI data	HIV-related medical visit in past 6 months	1 = Yes; 0 = No
ACASI data	Viral load test in past 6 months	1 = Yes; 0 = No
ACASI data	Currently taking ART	1 = Yes; 0 = No
	Ability to take ART among participants current taking ART	Continuous (range = 1-6)
ACASI data	Virally suppressed	1 = Yes; 0 = No or Don't know

Presentation of the results begins with plots showing changes in mean outcome levels over time based on the observed data. Random-effects regressions are used to estimate outcome trajectories over time and draw statistical inference.

Statistical methods applied medical chart data. Viral load data points were not aligned across participants over the follow-up period. Therefore, it was not practical to calculate means at discrete time points. Plots show viral suppression outcome trajectories that are estimated at each follow-up time point using locally weighted least squares (loess) regression. Each plot shows three outcome trajectories for participants with a new HIV diagnosis (within a year of the baseline assessment), participants with a more established HIV infection, and all participants.

Random-effects logistic regressions were fit to model changes in the probability of viral suppression over time. Models included an intercept term, time as a continuous covariate, and random effects for each participant. Plots suggest curvilinear outcome trajectories, but we were unable to get curvilinear time trends to fit. Time was modeled as a linear trend. Odds ratios (OR) and 95% confidence intervals

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(CI) are presented for the odds of viral suppression for each additional 30 days in the study. Models were fit to two subgroups of participants (i.e., participants with a new diagnosis and participants with established infection) and the entire sample.

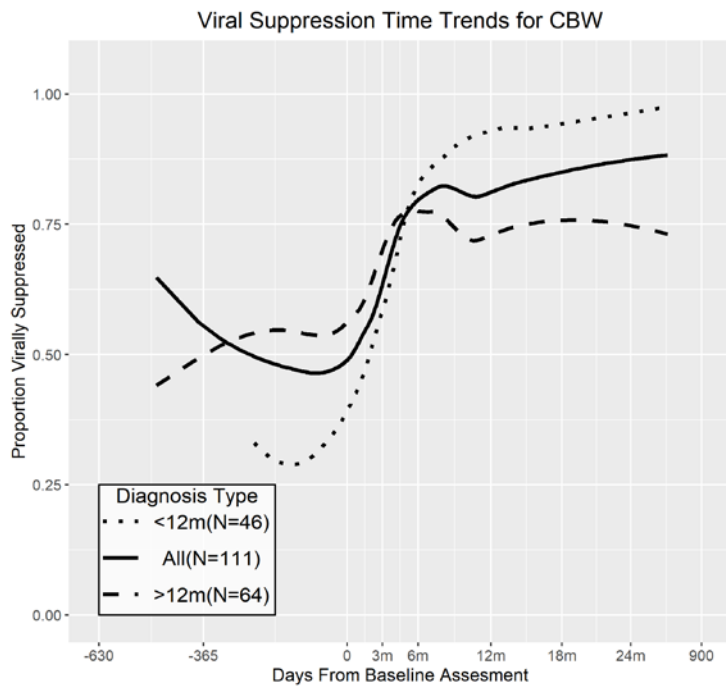
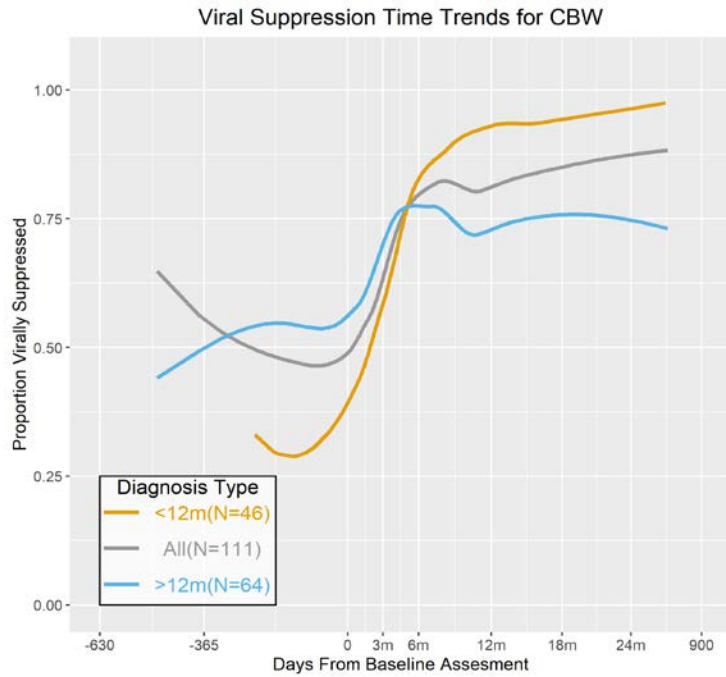
Statistical methods applied to ACASI data. Plots show mean outcome levels at each time point, including baseline, 6, 12, and 18 months. Each plot shows three outcome trajectories for participants with a new HIV diagnosis (within a year of the baseline assessment), participants with a more established HIV infection, and all participants.

Outcomes were modeled using random-effects logistic regressions for the probability of the outcome occurring (e.g., an HIV-related medical visit), except the outcome for the ability to take ART. Ability to take ART was treated as a continuous measure and modeled using linear random-effects regression for mean changes in ability. Similar to medical chart analyses, models included an intercept term, time, and random effects for each participant. Time was modeled as a categorical covariate. OR are shown for binary outcomes and compare the odds of the outcome occurring for each follow-up time point versus the baseline timepoint. Estimated mean differences between each follow-up time point and the baseline assessment are shown for the continuous outcome (ability to take ART). Models were fit to the subgroup of participants with established infection and the entire sample. We had difficulty fitting models to the subgroup of newly-diagnosed participants due to the smaller sample size.

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Medical chart data results.



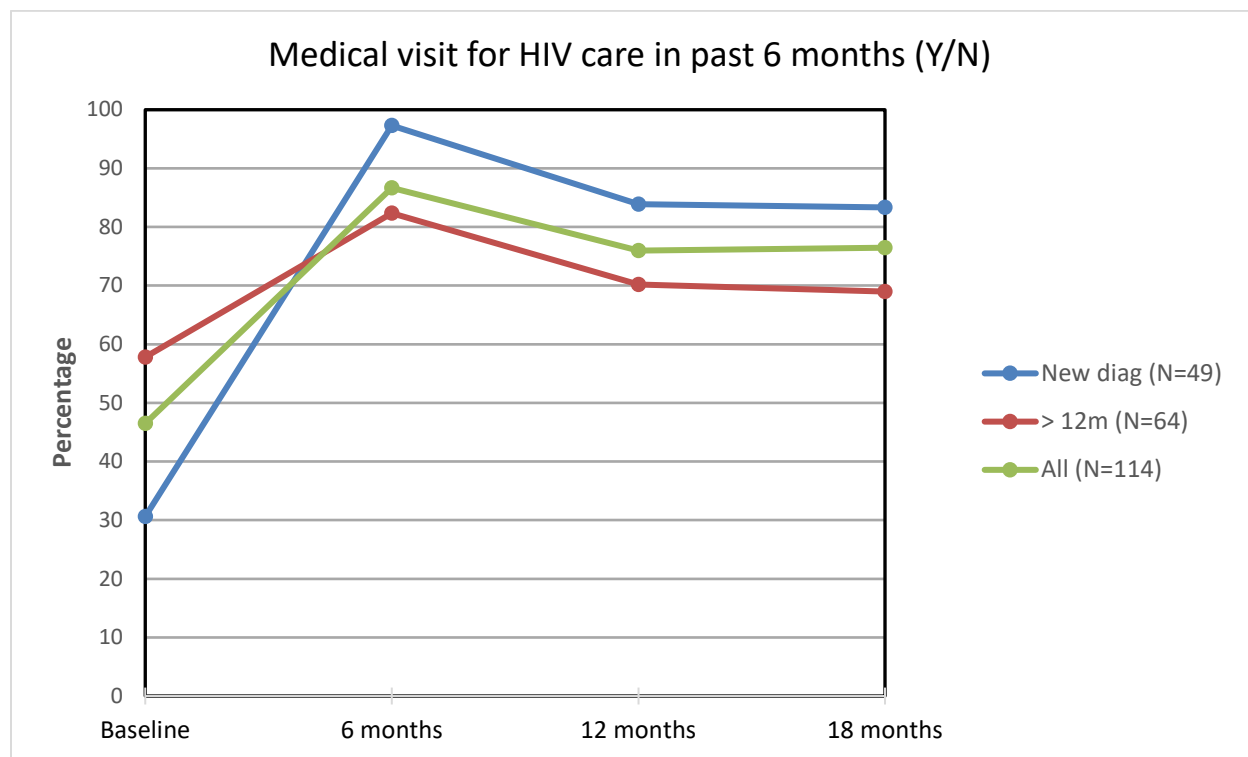
	Model	Beta Estimate	OR	95% CI	P-value
Overall		0.11	1.12	(1.08, 1.15)	0.00
Established Cases (>12 Mo.)		0.06	1.07	(1.03, 1.11)	0.00
Recent Cases (<12 Mo.)		0.23	1.26	(1.17, 1.35)	0.00

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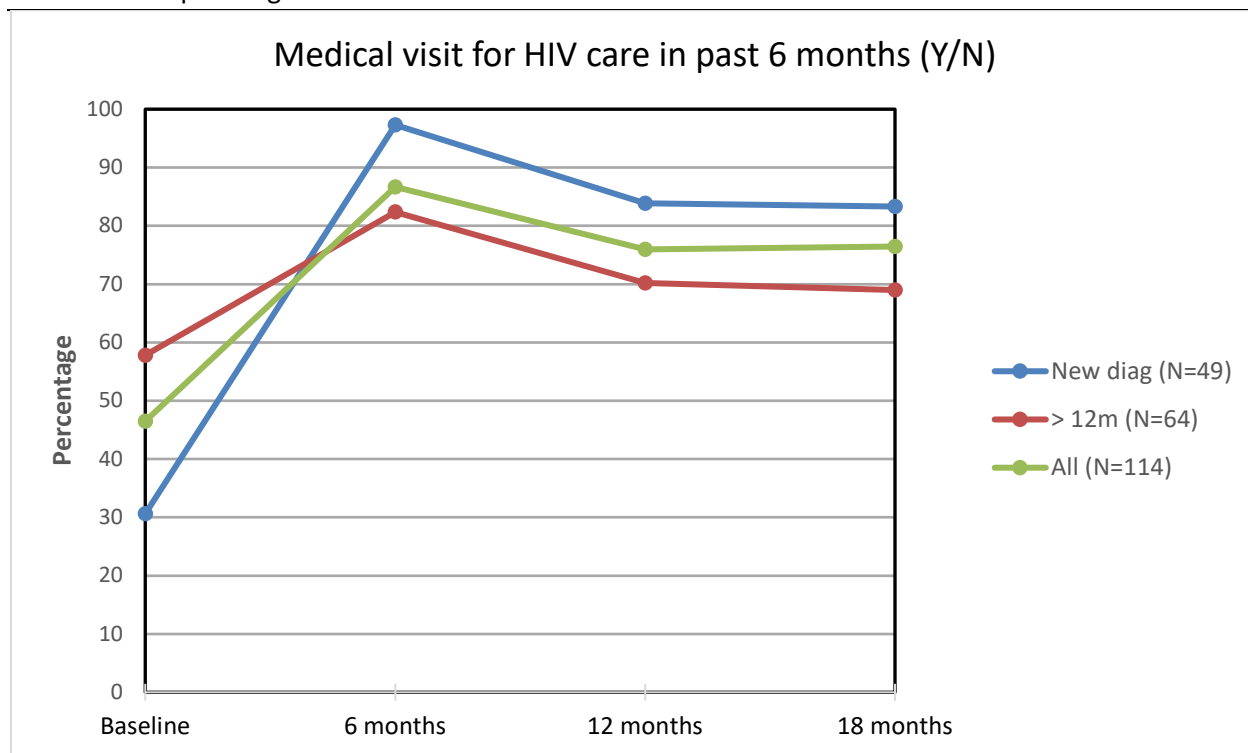
Based on the plot, there is a steep increase in viral suppression for both those with recent and established HIV diagnoses after baseline. After six months of intervention, newly diagnosed participants experience a steady rise in viral suppression while the established diagnoses level off, even slightly decreasing. These results are mirrored in the logistic regression results. For both newly-diagnosed participants and those with established infection, there is an increase in the odds of being virally suppressed for each 30 day increase in intervention exposure [OR=1.12, 95% CI (1.08, 1.15) in the entire sample]. The impact of the intervention is most pronounced for newly-diagnosed participants [OR=1.26, 95% CI (1.17, 1.35)].

ACASI data results. Plots showed increases in the probability of self-reported HIV-related medical visits, viral load testing, current ART utilization, and viral suppression. Similar to viral loads based on medical chart data, increases tapered off over the study period. Similarly, regression models indicated that the odds of medical visits, viral load testing, currently taking ART, and self-reported viral suppression increased at each follow-up time point relative to the baseline assessment with larger increases in the earlier time points. For example, the odds of medical visits were eight times higher at six months versus baseline, and closer to four times higher at 12 and 18 months after baseline. Increases in odds appeared to be driven more strongly by newly-diagnosed participants as the effects tended to be smaller among the subset of participants with established infection. Mean levels of self-reported ability to take ART remained fairly flat over the study period.



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Intervention Satisfaction Survey

Participant satisfaction with the intervention was evaluated using a survey administered after completion of all intervention components. Participants were asked to complete the Participant Satisfaction survey during the same appointment as the 6-month multisite evaluation survey; however, some Patient Satisfaction surveys were administered during the 12-month multisite evaluation survey. The Participant Satisfaction survey consisted of Likert scale, dichotomous, and open-ended questions which addressed each component of the intervention, mARTAS and Mobile Wellness. Of the 118 participants enrolled in the intervention, 75 participants completed the Participant Satisfaction survey.

Regarding mARTAS sessions, 68% of participants Strongly Agree/Agree that staff helped them outline steps to achieve their healthcare goals. In addition, 66% of participants Strongly Agree/Agree that staff helped them identify personal strengths and resources to help them overcome barriers to care. Finally, 70% of clients Strongly Agree/Agree that mARTAS influenced their linkage to care.

In response to questions about the Mobile Wellness component of the intervention, 73% of clients Strongly Agree/Agree that the health education text messages taught them new information about HIV and also led to healthier decision making.

Participants were also asked about “features” of the intervention such mode of communication and convenience. In response, 82% of participants felt comfortable discussing their health care through text

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message, 92% of participants strongly agree/agree that staff were readily available to answer their questions, and 96% of clients would recommend the program to others.

Open-ended Participant responses. Participants were asked open-ended questions about what they liked most about the intervention and what changes they would recommend. The open-ended responses were coded to account for common themes among participants. Among responses, only 2.67% mentioned program incentives such as gift cards, bus passes, and free cellphones with data plans as what they liked most about the program. The results bullet pointed below

- 14.67% mentioned receiving appointment and medication reminders
- 10.67% mentioned an increase in knowledge regarding HIV, healthcare, and/or program processes.
- 13.33% mentioned receiving social support
- 20% mentioned aspects related to communication including convenience, frequency, thoroughness and mode of communication.
- 20% mentioned positive staff attributes such as staff being perceived as caring, friendly, non-judgmental, etc.

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Lessons from the Field

Successes

While staff faced several challenges in implementing the Wellness Web intervention, overall intervention staff believe the intervention and the use of text messaging provided value to both clients and agency staff. Value provided to the clients includes easy, confidential access to social support after receiving an HIV-positive diagnosis, convenient method of asking questions about intake processes, and appointment reminders.

Overall agency staff benefits from intervention implementation. Implementation of the Wellness Web intervention facilitated communication between participants and case management staff. The navigation services provided during Wellness Web clarified the linkage to care process and made it less intimidating for newly diagnosed clients. Additionally, Wellness Web services ensured that clients were properly prepared for intake and case management appointments and improved efficiency by reducing the number of follow-ups necessary before linking to care or ensuring continuity of care at the 6-month renewal timeframe. Anecdotal evidence from intervention staff suggests that case management staff would be interested in expanding the ability to text message clients beyond only intervention staff as they occasionally asked intervention staff to pass on messages to participants.

Text message appointment reminders. Intervention staff scheduled appointment reminder text messages to be sent to clients 2-weeks, 1-week and 24-hours before their upcoming appointments. The timeframes at which the reminders were sent allowed clients to plan for their appointment by requesting time off work, making travel arrangements, or finding child care. If a participant anticipated that they would not be able to make necessary arrangements to attend their appointment, the reminders prompted participants to notify intervention staff that they needed to cancel or reschedule an appointment. It is believed that text message appointment reminders had a positive impact on medical appointment attendance. Additionally, 14.67% of participants mentioned receiving appointment and medication reminders as their favorite part of the program. It may be important to note the implementation sites only provided phone call reminders before implementation of the Wellness Web intervention.

Challenges

Intervention staff faced challenges with engaging participants in the intervention and adapting the intervention to meet specific needs of the client.

Engaging clients in mobile ARTAS sessions. Intervention staff faced challenges with engaging participants in mobile ARTAS sessions during the timeframes in which they were intended to be delivered. Ideally, the first mobile ARTAS session would happen within 48-hours after enrollment and mobile ARTAS sessions two through five would occur every 3-5 days afterwards until the client linked to medical care. Factors that affected client engagement levels with mobile ARTAS sessions included timing of mobile ARTAS sessions, style of communication, and rapport developed between staff and participants.

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Participants have diverse lifestyles that may include attending college or working multiple jobs. Because Wellness Web was designed to be client-centered, intervention staff schedules were flexible to allow for mobile ARTAS sessions to occur outside of intervention staff's normal 8am-5pm schedule. Additionally, if participants mentioned they had a busy schedule, intervention staff attempted to schedule times for mobile ARTAS sessions in advance. However, even with the flexible availability of staff, several clients did not engage in mobile ARTAS sessions. And while scheduling mobile ARTAS sessions in advance was effective for some participants, others missed their scheduled session times and required additional follow-up.

Throughout the intervention, intervention staff observed that participants responded differently to different styles of communication and attempts to initiate mobile ARTAS sessions. Initially, intervention staff were formal in their attempts to start mobile ARTAS sessions with participants. Intervention staff would schedule sessions in advance, ask clients to verify their identity by providing their assigned Participant ID number before starting the mobile ARTAS session, and then recap the purpose of the mobile ARTAS session. This formal approach only seemed effective for participants who preferred to schedule sessions. It is thought that participants who did not schedule appointments or did not "attend" their scheduled mobile ARTAS sessions, perceived this method as too impersonal for a text message conversation.

If participants were not responsive to formal methods of communication, intervention staff attempted to initiate conversations in a more casual manner by checking-in with the participant about their day. Intervention staff would then attempt to transition the conversation to content outlined for mobile ARTAS sessions.

If participants did not respond to intervention staff's attempts to build rapport through casual conversation, intervention staff would send the participant a direct question related to topics outlined for each mobile ARTAS session, such as "Your doctor's appointment is tomorrow. Have you thought of a list of questions to ask the doctor?". While these methods improved engagement, they were not effective 100% of the time as several participants never engaged in a mobile ARTAS session. Because mobile ARTAS sessions occur through text message, it is easier for clients to forget about mobile ARTAS sessions. Participants may also feel less pressure or guilt to participate because they do not have a strong relationship with the intervention staff and do not face any consequences for skipping appointments. Other organizations want to implement Wellness Web should anticipate some difficulty engaging clients in conversation and strategize how to improve engagement.

Tools to track participant progress. The original ARTAS requires participants and staff to work together on setting goals and outlining action plans to achieve those goals. Participants are given worksheets to write down their goals, outline steps in their action plan and track progress towards reaching their goals. Because Wellness Web occurs through text message, it can be difficult for participants to visualize their plan and progress. To overcome this challenge, intervention staff had to be very clear in their

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communication and occasionally provide more conversation recaps and schedule additional reminders than what is outlined in the policies and procedures.

Adapting conversations for clients reconnecting to care versus newly diagnosed. The original ARTAS is designed for individuals linking to care for the first time; however, Wellness Web attempted to engage participants who were reconnecting to care in mobile ARTAS sessions as well. This required staff to adapt the original ARTAS session outlines and conversation guides to be more relevant to clients reconnecting to care. To do this, intervention staff had to assess why the participant had fallen out of care and where would be a good place to start mobile ARTAS sessions. Some clients may face the same barriers as when they were first linked to care and others may face new barriers that they need assistance overcoming. For example, some clients reconnecting to care may need more information about HIV or help establishing a support system while others may only need help accessing resources such as stable housing and transportation to medical appointments.

Barriers/Limitations

Due to differences in funding, structural organization, and technological capabilities of varying organizations, barriers or limitations may exist which affect how other organizations replicate the Mobile Wellness intervention.

Providing free phones and services plans to participants in need. Barriers faced by young adults who were enrolled in the intervention included no access to a personal cellphone or unstable cellphone service. To overcome this barrier and allow a greater number of participants to enroll in the intervention, Wellness Web provided 23 participants with cellphones and 6-months pre-paid service cards with unlimited talk, text, and data. Of the participants who received phones, 6 participants reported the phone being lost, broken or stolen within 3 months of the intervention. Additionally, the majority of participants were unable to purchase additional pre-paid phone service after the free 6-months of service ended. Organizations considering implementing Wellness Web should evaluate 1) the need for phones and phone service among their target population, 2) funding feasibility of providing free phones and phones service, and 3) the potential benefits and long-term impact of providing free phones.

Providing free bus passes to participants facing transportation barriers. Low-income and homeless clients who do not have means of transportation, and often walk or ride a bike to different areas of town to receive various support services, are at high-risk for missing medical appointments. In order to address this issue, Wellness Web provided clients with 30-day bus passes with the potential to receive additional passes after their initial pass expires. Organizations considering implementing Wellness Web should consider 1) the need for transportation assistance among their target population, 2) which transit system (bus, train, partnerships with taxi companies, etc.) is most beneficial to participants, and 3) the availability of funds to provide bus passes to participants and for what length of time.

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Technological capacity to implement Wellness Web. Organizations who wish to implement Wellness Web need to have the technological ability to communicate with clients one-on-one in real time through SMS text message, schedule text message appointment reminders, and develop an automated health education text message delivery system like Mobile Wellness. Some of these features may be available as a part of an organization's EMR; however, others may only be available through the purchase of additional software. The Coastal Bend Wellness Foundation purchased a subscription with Wellpass, which provided CBWF with the above-mentioned capabilities and the following additional features:

- Wellpass comes with a phone number so staff do not have to give out their personal numbers to clients.
- Wellpass has an alert system which notifies staff when clients send messages containing words of distress.
- Wellpass has a conversation export feature which is useful for documenting and reviewing conversations for quality assurance.
- Wellpass has an export feature that tracks metrics such as the number of staff/client touchpoints.

Organizations will need to evaluate their current technological capabilities to determine if they need to purchase additional software to implement Wellness Web. Other factors to consider include sustaining the cost for additional software, how the projected number of staff and participant will affect the cost of software, policies for when and where staff access the platform and participant information.

Organizational structure. Wellness Web was implemented in two different types service settings – 1) participants can receive medical care, case management, and most social support services from one agency in one building, and 2) participants may have to visit different agencies and/or different locations to receive medical care, case management, and other support services. Variances in organizational structure is a barrier to uniform implementation of Wellness Web from site to site. Organizations should consider their unique organizational structure and adapt delivery of Wellness Web accordingly to provide the greatest benefit to participants and staff.

The main implementation site for Wellness Web was at the Coastal Bend Wellness Foundation (CBWF), a 501 (c) 3, Federally Qualified Health Center. CBWF is a one-stop-shop for clients to receive outreach and prevention services, primary medical care, specialized treatment such as for HIV and Hep C, behavioral health services, and case management services. Clients who test positive for HIV through the Community Health Outreach department can access Ryan White case management services and healthcare in the same building following a smooth workflow and inter-department referral process. Intervention staff found that intervention delivery ran the most smoothly in this setting. Intervention staff were more easily integrated into the care team and were better able to facilitate communication between participants and care team staff.

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At Wellness Web sub-contractor sites, San Antonio AIDS Foundation and Laredo Health Department, it was not uncommon for participants to access one or two services, such as HOPWA or case management, at the sub-contractor site and see a medical provider with another organization. This structure provided challenges for intervention staff such as inability to access appointment information in order to schedule appointment reminders or difficulty helping participants navigate services with unfamiliar organizations. Based on intervention staff observations, challenges arose due to mistrust about sharing confidential client information across different organizations even with a signed release, and concerns over duplications of effort. During the pre-implementation phase, organizations considering implementing Wellness Web who also have this structural challenge will need to emphasize building relationships with different organizations and formalizing methods of sharing information. Intervention staff will also need to learn the process for accessing services at these different organizations in order to effectively help clients navigate the services that are available to them in a timely manner.

Integrating intervention staff into care team. Different organizations may vary the degree to which they integrate intervention staff into the care team. In order to facilitate communication between care team staff and participants, it is recommended that intervention staff be included in care team meetings or meet regularly with case managers to discuss barriers to care mentioned by participants during mobile ARTAS sessions. Additionally, intervention implementation ran more smoothly when intervention staff had access to CBWF's electronic medical record (EMR) system. Access to the EMR, allowed intervention staff to be proactive in looking up medical appointments so they could schedule medical appointment reminders and follow-up with clients after medical appointments were scheduled. Without access to the EMR, an additional workload would have been placed on clinic staff to look up and send appointment dates and times to intervention staff.

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Monitoring and Evaluation

The overarching goal of the evaluation plan of Wellness Web 2.0 is a systemic process for planning, designing, assessing, and improving performance of the intervention. Information derived from Monitoring and Evaluation activities are important mainly for two reasons:

- 1) Monitoring aspects of implementation and providing ongoing information concerning areas that might need improvement
- 2) Inform future programming and funding decisions

Consistent with these two main goals, Wellness Web 2.0 evaluation plan includes the following components:

- A. Employ assessment procedures to determine efficacy and appropriateness and to judge how well services are delivered and where opportunities for improvement within the proposed model exist.
- B. Focus on improving quality of services in all of its dimensions by implementing multidisciplinary, data driven, project teams and encouraging participatory problem solving.
- C. Promote communication, dialogue and informational exchange across the department and throughout the organization’s reporting structure, with regard to findings, analyses, conclusions, recommendations, and actions pertaining to performance improvement.
- D. Establish a strong and open collaboration with the multi-site ETAC where data can be shared in real-time through the utilization of existent and new reporting systems as needed.

Aims for Local Evaluation. Overall the local monitoring and evaluation of Wellness Web 2.0 focuses on two main areas:

- I. Assess the impact of the intervention on individual’s overall quality of life and
- II. Assess the process of modifying, implementing, and delivering the intervention

To achieve this, the following Process and Outcome measures were selected – see Table 4: Outcome Evaluation and Table 5: Process Monitoring

Table 4: Outcome Evaluation

Outcome Question	Performance Measure	Data Source	Frequency	Responsibility (Recommended)
What is the impact of Intervention in patient HIV/Health indicators, and other indicators?	HIV indicators: positivity, late diagnosis, linkage to medical care, retention in care, ART therapy, viral load suppression.	EHR	Baseline, 6-, 12-, & 18-mo. F/U	Project Director
What is the satisfaction level of those completing Wellness Web 2.0?	Level of client’s satisfaction with WW2.0 interventions, delivery methods, and staff.	Client Satisfaction Questionnaire	At 6-month F/U	Social Media Specialist/Project Director

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Table 5: Process Monitoring

Process Question	Performance Measure	Data Source	Frequency	Responsibility (Recommended)
What is the level of fidelity to mARTAS?	Are contact protocols followed? Are delivery workflows followed adequately?	Observation	At least one assessment for each ARTAS session per Social Media Specialist	Project Coordinator
What are the challenges/barriers of mARTAS implementation?	Documentation of barriers/challenges experienced as well as efforts to overcome them.	Tracking Report	Monthly	Project Coordinator
What is the level of direct client exposure to mARTAS?	Preferred modality, direct service dosage, and level of exposure	Tracking Report	Monthly	Project Coordinator

Participants / Sample for Local Evaluation. The sample for local evaluation included all individuals who met eligibility criteria for participation in the SPNS Social Media Initiative. To meet eligibility, potential participants must meet all of the following:

- A. Be between the ages of 13 and 34;
- B. Be HIV positive;
- C. Meet at least one of the following:
 - Newly diagnosed with HIV: tested HIV positive for the first time within the past 12 months
 - Not linked to care: aware of HIV positive status, but have never received HIV care
 - Out of care/not retained in care: diagnosed over 12 months ago, but has a gap in care greater than six months in a 24 month period.
 - Not virally suppressed: viral load of ≥ 200 copies/mL at last lab test.
- D. Be willing and able to access new media platforms (i.e., access to Smartphone/computer)
- E. Provide informed consent if 18 or older or informed assent and parental consent if younger than 18 years of age.

Methods for Local Evaluation. The evaluation of Project Wellness Web 2.0 is a quantitative, pre and post, quasi experimental design focusing on the assessment of changes in client behaviors across time. Client-data is collected at four timepoints:

1. Baseline: immediately upon enrollment into project
2. Six-month follow-up: five to seven months after baseline completion
3. 12-month follow-up: 11 to 13 months after baseline completion
4. 18-month follow-up: 17 to 19 months after baseline completion

Data collection. Each client is explained in private the purpose of Project Wellness Web 2.0, expectations from participation and confidentiality. After informed consent is obtained, clients are

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asked to complete the baseline survey. Data is gathered via an audio-enhanced computer-assisted self-interviewing (ACASI) survey administered to each client using a tablet or laptop computer. (See Appendix 9 for ACASI Survey Instrument Questions). Each client is provided with a private space to complete the survey and a staff member is readily available in case there are any questions or technical problems with the survey. Once a survey is completed, the staff saves the survey to the indicated folder in each laptop (See Appendix 8 for Data Collection Workflows).

Patient Satisfaction is collected at the 6-month follow-up. The instrument is a 21-item questionnaire measuring client satisfaction with overall program, staff, and services provided (See Appendix 7).

Process data is collected using a variety of sources and data collection methods which include:

1. Intervention Exposure
 - Person-to-person – daily frequency of contacts (via text or phone call), who initiated contact, reason for contact and number of messages exchanged.
 - Back-end data – Daily number of automated messages sent to each client, topics, covered, and responses received from clients.
2. Medical Chart Data – HIV and health-specific data gathered via hand extraction from the clinic’s Electronic Health Records. Collected every 5 months.
3. Costing – staff salary & benefits, hours worked, and % spent on varied activities. Collected monthly.

Data analyses. Statistical analyses will be performed once enough number of clients have completed both baseline and at least 6-month follow-up instrument wo allow enough power for analyses. Analyses will include Repeated Measures ANOVA and chi-square analyses.

Staff roles and responsibilities. Monitoring and evaluation is performed based on a team approach where project management, direct staff and external evaluator collaborate and communicate in an on-going basis. The external evaluator takes the lead in managing the evaluation plan; however different activities are implemented by different members of the project team as follows:

Title or Role	Responsibilities
Project Director	Oversee data extraction and monitor completion of monthly logs Lead reporting activities
Project Coordinator	Lead costing, medical chart, and exposure log data collection ACASI survey submission Coordinate data collection activities and transfer of data between agency and evaluator Monitor due dates Ensure confidentiality of all data, proper identification of records, and proper storage of records. Perform preliminary quality assurance checks
Social Media Specialist	Track direct client contacts, administer ARTAS specific questionnaires
Evaluator	Manage all data including submission to assigned portals/databases Perform thorough quality assurance checks Analyze and report on data to project management and other stakeholders Monitor project milestones

Appendices

1. *Job Description and Recruitment*
 - a. Project Director Job Description
 - b. Project Coordinator Job Description
 - c. Social Media Specialist Job Descriptions
 - d. Open Position Advertisements
2. IRB
3. *Subcontractor Agreement*
4. *Community Assessment*
 - a. Community Assessment Questions
 - b. Community Assessment Results
5. *Marketing Material Evaluation*
 - a. June 2016 Initial Social Media Campaign Evaluation Questions
 - b. June 2016 Initial Social Media Campaign Evaluation Results
 - c. Feb 2017 Social Media Campaign Evaluation Questions
 - d. Feb 2017 Social Media Campaign Evaluation Results
 - e. April 2017 Social Media Campaign Evaluation Questions
 - f. April 2017 Social Media Campaign Evaluation Results
 - g. Social Media Advertising Images
 - h. Dating App Advertising Images
 - i. Outdoor Advertising Images
6. *Recruitment & Enrollment Forms*
 - a. Referral Form
 - b. Screening Form
 - c. Client Locator Form
 - d. Adult Informed Consent – English & Spanish
 - e. Youth Informed Assent – English & Spanish
 - f. Parent/Guardian Informed Consent – English & Spanish
 - g. SenseHealth Consent Form – English & Spanish
 - h. WellnessWeb Phone Service Consent Form – English & Spanish
 - i. Patient Intake Notes Form
 - j. Patient Navigation Paperwork
 - i. CBWF New Patient Intake Packet – English & Spanish
 - ii. Case Management Info Card – English & Spanish
 - iii. HIV Health Care Info Card – English & Spanish
 - iv. HIV 101 Info Sheet – English & Spanish
 - v. Doctor Discussion Guide
 - vi. Supporter’s Statement – English & Spanish

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- vii. No Income Statement – English & Spanish
- 7. Participant Engagement Data Collection Forms
 - a. mARTAS Participant Engagement Spreadsheet
 - b. Mobile Wellness Participant Engagement Spreadsheet
 - c. Client Satisfaction Survey – English & Spanish
 - d. Client Satisfaction Survey Results
- 8. *Intervention Guidelines, Protocols and Workflows*
 - a. Outreach and Recruitment
 - i. Internet Based Outreach Guidelines
 - ii. Outreach and Recruitment Protocols
 - iii. Social Media Account Authorization Form
 - iv. Outreach & Enrollment Workflow
 - b. Screening and Enrollment
 - i. Screening and Enrollment Protocol
 - c. mARTAS Adaptation
 - i. mARTAS Training PowerPoint
 - ii. mARTAS Workflow
 - d. Wellpass Platform Policy & Procedure
- 9. *ACASI Survey Instrument*

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