weCARE: A Social Media–Based Intervention Designed to Increase HIV Care Linkage, Retention, and Health Outcomes for Racially and Ethnically Diverse Young MSM

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Abstract:

Estimates suggest that only about 30% of all individuals living with HIV in the U.S. have achieved viral suppression. Men who have sex with men (MSM), particularly racial/ethnic minority young MSM, are at increased risk for HIV infection and may have even lower viral suppression rates. HIV testing rates among MSM are low, and when tested, racial/ethnic minority young MSM have disproportionately lower rates of retention in care and viral suppression compared to other subgroups. This article describes the design and development of weCare, our social media-based intervention to improve care linkage and retention and health outcomes among racially and ethnically diverse MSM, ages 13-34, living with HIV that will be implemented and evaluated beginning in late 2016. The intervention harnesses established social media that MSM between these ages commonly use, including Facebook, text messaging, and established GPS-based mobile applications (apps). We are using community-based participatory research (CBPR) to enhance the quality and validity of weCare, equitably involving community members, organization representatives, healthcare providers, clinic staff, and academic researchers.

Keywords: MSM | HIV/AIDS | social media

Article:

Despite advances in HIV diagnostics, treatment, and behavioral interventions to increase medication adherence, youth and young adults continue to have low rates of care linkage and retention. An estimated 29% of HIV infections occur among youth and young adults ages 13‐29, and over 1,000 new infections per month occur among this age group (Centers for Disease Control and Prevention [CDC], 2011). It is estimated that less than half of youth ages 13‐24 with

HIV know their status, one quarter are in care, and only 6% achieve viral suppression (compared to 24% among adults; Tanner, Philbin, & Ma, 2014; Zanoni, & Mayer, 2014). The greatest number of infections among youth and young adults occur among racial and ethnic minority young men who have sex with men (MSM; CDC, 2012, 2013, 2015a).

MSM of all races/ethnicities and age groups continue to be disproportionately affected by HIV, accounting for nearly two-thirds of all new infections in the U.S. (CDC, 2013; Johnson et al., 2013). Although the overall annual HIV diagnosis rate decreased by 33.2% from 2002 to 2011, the number of new HIV infections among MSM has continued to increase. For example, the rate of new HIV diagnoses among MSM is 44 times that of other men and 40 times that of women (Johnson et al., 2013, 2014). Among all MSM, African American/Black and Latino MSM carry a disproportionate burden of HIV, resulting in profound HIV-related health disparities. These national trends hold true in the U.S. South, which is often referred to as the new HIV epicenter in the U.S. (AIDSVu, 2013). For example, in North Carolina MSM accounted for 77% of all the new HIV cases in adult/adolescent males (North Carolina Department of Health and Human Services, 2012). African American/Black and Latino MSM had rates nearly eight times and three times, respectively, the rate for White men, with racial/ethnic minority youth also disproportionally affected (CDC, 2015b).

Thus, a clear need exists for innovative interventions to improve outcomes among racially and ethnically diverse young MSM and to achieve the objectives of the National HIV/AIDS Strategy, which prioritizes reducing HIV incidence, increasing access to care, optimizing health outcomes, and reducing HIV-related disparities (White House Office of National AIDS Policy, 2015).

CARE CONTINUUM: OVERVIEW AND CHALLENGES

While the HIV Care Continuum identifies HIV testing, care linkage, initiation of antiretroviral therapy (ART), and care retention of young MSM as public health priorities (Mayer, 2011; Tanner et al., 2014), there are many places across the Continuum that may be missed opportunities for linkage and engagement and/or where young MSM may disengage. Failures in care across the Continuum are common and associated with lower levels of viral suppression and greater likelihood of HIV transmission and viral resistance (Bradley et al., 2014; Kurth, Lally, Choko, Inwani, & Fortenberry, 2015; MacCarthy et al., 2015; Tanner, Philbin, & Ma, 2014; Vissman et al., 2011). Racial/ethnic minority young MSM may face even greater challenges to care and viral suppression because of the co-occurring challenges of prevalent substance use and mental health issues, as well as stigma, discrimination, and marginalization (Minniear et al., 2013; Tanner, Philbin, & Ma, 2014).

Individual factors, such as readiness for care, have the potential to affect care linkage and retention and viral suppression. Data show that care linkage and retention often require flexibility and persistence in maintaining ongoing contact with youth and young adults not yet ready to engage in HIV care (Philbin, Tanner, DuVal, Ellen, Kapogiannis, et al., 2014; Philbin, Tanner, DuVal, Ellen, Xu, et al., 2014). The stigma that results from an HIV-diagnosis and fear of rejection by family, peers, and community have significant effects on young MSM (Moore, 2011). Development of self- and social-identities during middle and late adolescence additionally affect the acceptance of the HIV diagnosis, which is associated with higher rates of depression,

anxiety, and social isolation among HIV-positive youth and young adults (Blum, 1992; Committee on Pediatric AIDS AAoP, 1999; Futterman, Chabon, & Hoffman, 2000; Orr, Weller, Satterwhite, & Pless, 1984; Pao, Lyon, D' Angelo, Schuman, Tipnis, & Mrazek, 2000; Safren et al., 2004).

Lacking experience with clinics and healthcare providers may further complicate the ability of young MSM to navigate the healthcare system. Youth and young adults are more likely to receive HIV testing in community-based rather than clinic-based venues where rates of successful care linkage are lower (Bradley et al., 2014). Access to and retention in HIV care may be challenging as clinics are conceptualized as places that require advanced skills. Youth and young adults may lack the skills necessary to negotiate clinical policies and procedures (e.g., appointment scheduling, payment, insurance, and residency/immigration documentation), especially within clinics without bilingual and bicultural services. Moreover, studies have shown that clinic staff attitudes often communicate larger messages of homophobia, race- and ethnicity-based discrimination, and HIV-related stigma (Kempf et al., 2010; Lichtenstein, 2003; Lichtenstein, & Bachmann, 2005). Helping young HIV-positive youth better manage and negotiate clinical space may improve care linkage and retention and, consequently, viral suppression (Hutton, 2008, 2010; Macfarlane, & Blum, 2001; Tanner, Philbin, Duval, et al., 2014).

Youth and young adults also need support in overcoming structural barriers to HIV care such as access to health insurance and transportation. Youth and young adults—especially those who are low income and/or racial/ethnic minorities—are over-represented in the approximately 10% of American children and adolescents without health care insurance of any kind (Bethell et al., 2011). Lack of insurance limits subsequent care retention of newly diagnosed youth and young adults, especially if alternative means of payment are unavailable (Moore, 2011; Ulett et al., 2009). Similarly, transportation is uniformly cited as a barrier to care, especially in areas with limited public transportation systems (Fortenberry, Martinez, Rudy, & Monte, 2012; Kempf et al., 2010; Zaller et al., 2008). These types of unique challenges that youth and young adults face require creative and innovative approaches to improve HIV care, such as the use of social media.

SOCIAL MEDIA USE AMONG YOUNG MSM

Young MSM have high rates of social media use, including Facebook, text messaging, and GPS-based mobile applications (apps) designed for social and sexual networking, e.g., Adam4Adam (A4A)/Radar, badoo, Grindr, Jack'd, and SCRUFF. These rates of social media use are largely related to increased access to smartphones and other mobile devices (Sun, Stowers, Miller, Bachmann, & Rhodes, 2015). In a recent study of MSM, 72% owned a smartphone or other mobile device and an additional 9% planned to buy one in the next year (Grov, Ventuneac, Rendina, Jimenez, & Parsons, 2013).

Facebook is the most commonly used mobile social media site, used in 2014 by 58% of all U.S. adults and 71% of adult internet users (an increase from 67% in 2012; Duggan, Ellison, Lampe, Lenhart, & Madden, 2015). Rates of use are highest among online adults ages 18–29 (87%) and among Latino adults (73%; Duggan et al., 2014a). Furthermore, users tend to access Facebook frequently; 70% of adults who use Facebook report using the site daily, 45% report using it more

than once a day, and 65% report that they frequently or sometimes share, post, or comment on Facebook. Only 12% of Facebook users report using the site less than once per week (Duggan et al., 2014b). At the same time, texting continues to increase dramatically among all age groups. Adults who text typically send and receive a median of 10 texts a day while teenagers who text send and receive a median of 50 texts per day. Racial/ethnic minorities tend to send more text messages than nonracial/ethnic minorities (Smith, 2011).

Social and sexual networking apps are also common among MSM; for example, Grindr has 3‑6 million active users in 192 countries (Phillips et al., 2014; Sun et al., 2015; Sun, Alonzo, Garcia, Reboussin, & Rhodes, 2016). Using GPS features users can locate, chat, and meet up with other MSM using the same app. As our team (Sun et al., 2015, 2016) and others (Beymer et al., 2014; Grov, Breslow, Newcomb, Rosenberger, & Bauermeister, 2014; Holloway, 2014; Muessig, Pike, Fowler, et al., 2013; Young, Szekeres, & Coates, 2013) have found that apps are an important tool for social support, meeting friends, building community, and sexual networking for many young MSM; MSM who use these types of apps may be at increased risk for HIV. Although research is just emerging, app users tend to: have lower HIV testing rates (Rendina, Jimenez, Grov, Ventuneac, & Parsons, 2014; Sun et al., 2015), and higher numbers of sexual partners (Landovitz et al., 2013; Phillips et al., 2014; Sun et al., 2016; Young et al., 2013), and be more likely to report: sex with both men and women (Rhodes, McCoy, et al., 2016; Sun et al., 2015), alcohol and drug use during sex (Beymer et al., 2014; Landovitz et al., 2013; Winetrobe, Rice, Bauermeister, Petering, & Holloway, 2014; Young et al., 2013), unprotected anal intercourse (Landovitz et al., 2013; Rhodes & McCoy, 2015; Winetrobe et al., 2014), and a sexually-transmitted infection (STI) history (Beymer et al., 2014). In addition, it has been suggested that some app users are hard to reach because they may be less likely to: be exposed to venue-based prevention efforts (e.g., those that are in gay bars/clubs or community based), disclose same-sex behaviors and sexual risks to health providers, identify with gay-focused prevention messages, and may have challenges engaging in HIV-related care (Bull, Walker, & Levine, 2014; Holloway, 2014; Holloway et al., 2014; Lewis, Uhrig, Ayala, & Stryker, 2011; Noar & Willoughby, 2012; Rhodes et al., 2014).

The frequent and active engagement with Facebook, texting, and social and sexual networking apps suggest that these are potentially powerful tools for HIV-related education, prevention, and care especially given that they are widely available, inexpensive, and instant, thus holding promise as interactive platforms for health promotion and disease prevention interventions (Bull, 2014; Bull et al., 2014; Christopoulos et al., 2014; Cole-Lewis, & Kershaw, 2010; Horvath, Azman, Kennedy, & Rutherford, 2012; Mbuagbaw et al., 2015).

STUDY PURPOSE

Building on our team's ongoing expertise using social media, including Facebook, text messaging, and apps to promote HIV testing (Bachmann et al., 2013; Rhodes, 2004; Rhodes, Vissman, et al., 2011; Sun et al., 2015, 2016) as well as our research with youth and young adults with HIV (Tanner, 2008; Tanner et al., 2013; Tanner, Philbin, Duval, et al., 2014; Tanner, Philbin, & Ma, 2014; Tanner, Reboussin, et al., 2014; Tanner, Secor-Turner, Garwick, Sieving, & Rush, 2012; Philbin, Tanner, DuVal, Ellen, Kapogiannis, et al., 2014; Philbin, Tanner, DuVal, Ellen, Xu, et al., 2014; Vissman et al., 2011; Vissman, Young, Wilkin, & Rhodes, 2013), we are

in the development phase of a 4-year Health Resources and Services Administration (HRSA) funded project to design a social media intervention to improve care linkage and retention among underserved, underinsured, and hard-to-reach, racially and ethnically diverse young MSM with HIV. The purpose of this paper is to describe design and development of, weCare, our social media-based intervention to improve care linkage and retention and health outcomes among racially and ethnically diverse MSM, ages 13‑34, living with HIV. weCare will be implemented and evaluated beginning late 2016.

METHODS

INTERVENTION OVERVIEW

weCare is our innovative, tailored intervention that harnesses established social media platforms that young MSM commonly use. See Figure 1 for the weCare logo. The intervention is supported by the HRSA Special Projects of National Significance (SPNS) initiative, founded on the Health and Human Services (HHS) Common HIV Indicators for Use with the HIV Care Continuum, and designed to improve care linkage and retention and health outcomes (i.e., viral load suppression) among underserved, underinsured, and hard-to-reach racially and ethnically diverse young MSM. To ensure the highest level of acceptability and meaningfulness of the intervention, we are using a community-based participatory research (CBPR) approach.

Figure 1. The weCare intervention logo.

CBPR can yield deeper and more informed understanding of health-related phenomena and produce interventions and programs that are more relevant, more culturally congruent, more likely to be effective, and more likely to be adopted and sustained if effective and warranted (Rhodes, 2012; Rhodes, Duck, et al., 2013; Tanner, Philbin, & Ma, 2014). Similarly, study designs, including those to evaluate interventions and programs, that are informed by multiple perspectives of community members, organization representatives, healthcare providers, clinic staff, and academic researchers may be more authentic to the community and to ways that community members engage, convene, interact, and make change. Thus, interventions developed and evaluated using a CBPR approach may be more innovative and more relevant and realistic; recruitment benchmarks, including participation and retention rates, may be higher; analysis and interpretation of findings may be more accurate; sustainability may be more likely; and

dissemination may be broader (Rhodes, 2012; Rhodes et al., 2007; Rhodes, Malow, & Jolly, 2010; Rhodes, Duck, et al., 2013, Rhodes et al., 2014).

weCare comes out of an existing CBPR partnership that has >14 years of doing HIV-related research in partnership with racially- and ethnically-diverse MSM communities (Rhodes et al., 2014). As such, this project is guided by a steering committee that oversees the project in terms of using the most culturally congruent approach to recruitment and retention, intervention delivery, creating targeted and meaningful intervention messages, and employing creative problem solving. The steering committee is comprised of members from the local catchment area, including racially and ethnically diverse young MSM (some of whom are HIV positive) and the project team.

The intervention is based on our project team's ongoing research using Facebook, text messaging, and social and sexual networking apps, and is tailored to the social media preferences of each participant, given that among young MSM there may be variations in use of different social media platforms. The weCare Health Educator will use a combination of Facebook messenger, text messaging, and app-based instant messages, based on the participants' preferences, to communicate with each participant individually using theory-based messages specific to each participant's place on the Continuum (see Table 1). These messages can be tailored to the specific context of the participant (e.g., age, time since diagnosis, and/or specific challenges with care) to assist in addressing individual participants' unique needs (e.g., communicating with providers, challenges with family, navigating healthcare coverage, and other sexual health education such as PrEP information for participants' sexual partners). The Health Educator also will manage an optional Facebook secret group for participants. In addition to the social media interactions, the Health Educator will have some face-to-face interactions (e.g., at delivery of HIV diagnosis, at clinic when participants come in for appointments). These face-to-face interactions will help with relationship development and trust building and lay the foundation for communication via social media, as in other studies we have found that these interpersonal connections are valuable for participant recruitment and retention (Rhodes, Daniel, et al., 2013; Rhodes, Alonzo, et al., 2015) and will likely assist with improving health indicators (Table 1).

Table 1. Overview of weCare Intervention Strategies for Moving Young MSM Across the Continuum

Stage along the Continuum	**Diagnosis**	**Care linkage**	**Care retention**	**ART Rx**	**Viral suppression**
Example Health Educator Strategies	Meet (in person), build trust and rapport, determine social media preferences	Provide reminders; de-mystify clinic processes; problem solve to reduce barriers; applaud positive behaviors, via preferred social media	Explore why appointment was missed; problem solve to reduce barriers; provide appointment reminders; applaud positive behaviors; check-in; offer social support, via preferred social media	Provide prescription fill reminders; problem solve to reduce barriers; applaud positive behaviors, via preferred social media	Provide reminders to take medications; problem solve to reduce barriers; applaud positive behaviors, via preferred social media

We will collect and analyze main outcomes using these HHS Common HIV Indicators for Use with the HIV Care Continuum as described in Table 1: care linkage and retention, ART prescription and adherence, and viral suppression. Data on these indicators will be abstracted from electronic health records to evaluate weCare. The dose of the program (e.g., number of social media and face-to-face interactions) will be managed by the Health Educator through a participant log using REDCap which is a secure and web-based data collection application.

THEORETICAL UNDERPINNINGS OF INTERVENTION

Social media communications between the Health Educator and participants will be based on social cognitive theory and the theory of empowerment education. Social cognitive theory emphasizes information; mastery of skills and development of self-efficacy; enhancement of proficiency; and social support for behavior change/action (Bandura, 1986, 1994, 1997; Rhodes, Vissman, et al., 2011). Thus, we will identify and fill knowledge gaps (e.g., what to expect when attending one's first clinical appointment after an HIV diagnosis). A participant may express discomfort so the Health Educator will help increase self-efficacy by identifying and then reducing perceived barriers (e.g., perceptions that one will be judged by clinic staff). The Health Educator may also role-play (via social media) by having the participants practice asking questions of their provider, support incremental steps (e.g., filling an ART prescription), and reinforce HIV care behaviors (e.g., taking ART as prescribed). Further, as empowerment education posits that individuals move beyond learning and critically reflect to get to action (Eng, Moore, & Rhodes, 2005; Freire, 1970, 1973; Rhodes, Vissman, et al., 2011), the Health Educator will be trained to use conversation triggers to promote critical consciousness. For example, using app-based instant messaging he might applaud a participant who reports getting an ART prescription after diagnosis, and also ask him how he plans to get the prescription filled. As norms and expectations contribute to risk, raising consciousness is key and best facilitated by community insiders such as the Health Educator through social media platforms that the participants are already using.

Trained community insiders, who are natural helpers, can provide support as a peer who is socio-economically and experientially similar; possess an intimate understanding of social networks, strengths, and health needs (including worries) and priorities; understand what is meaningful and motivational to those like themselves; communicate in a similar style and language; and recognize and incorporate cultural identities (including both racial/ethnic and sexual minority cultures; Eng, Rhodes, & Parker, 2009). We have seen in our research how insiders can be highly effective to promote health and health outcomes among those within their own communities (Eng et al., 2009; Rhodes, 2004; Rhodes, Leichliter, et al., 2016; Rhodes, Hergenrather, Bloom, Leichliter, & Montano, 2009; Rhodes, McCoy et al., 2011; Rhodes, Vissman et al., 2011; Vissman, Eng, Aronson, & Rhodes, 2009). Thus, the Health Educator will use social media-based communication to: de-mystify the HIV treatment process, help to link and engage newly diagnosed young MSM to care, offer social support and resources to deal with stigma and fears of rejection, provide guidance for navigating the clinic, and support contingency plans for managing transportation.

Aligning with the theoretical underpinnings of weCare, the Health Educator for the project is a young Latino MSM with extensive experience in facilitating HIV-related interventions (including those utilizing social media) and great success in both recruitment and retention of other MSM and transgender women. We anticipate this as a major strength of the successful implementation of the weCare initiative.

INTERVENTION PRODUCTS AND ACTIVITIES

Based on successful social media interventions, and underlying theories, we are adapting and developing activities and materials for this intervention and developing a Health Educator Intervention Training Guide, which includes didactic, interactive, and skills-building modules to train the Health Educator in the intervention protocols and the nuts and bolts of intervention delivery: how to interact within the social media platforms, how to establish rapport and start building trust with participants through social media, how to be supportive to them but not intrusive, and other roles and responsibilities when interacting with participants (e.g., sending messages to check in, offering support and resources to deal with stigma and fears of rejection, and reminding participants to bring questions for their providers to their appointments). We are also scripting theory-based messages for the Health Educator to use and adapt to meet participants' specific context (e.g., age, time since diagnosis, and/or specific challenges with care) during implementation via Facebook messenger, text messaging, and app-based instant messages.

Because Facebook and app platforms allow for profiles, the Health Educator is creating Facebook and app profiles (within A4A/Radar, badoo, Grindr, Jack'd, and SCRUFF), which he will use to communicate with project participants about HIV care linkage and retention once enrolled in the intervention. These profiles (in addition to the other materials and messages) are being created in collaboration with, and will be approved by, the steering committee and the Wake Forest School of Medicine Institutional Review Board and are designed to spark interest among intervention participants, provide information about the intervention, and accurately represent the Health Educator's roles, including his affiliation with the project and purpose within the social media sites. All profiles will be bilingual (English and Spanish) to reach diverse MSM, including Latino MSM. We will post standardized theory-based conversation triggers on social media profiles. We will change the triggers two or three times a week. As we have learned that Facebook and app users also respond to profile photos, the Health Educator will change his profile photo once per week; the photos will be real G-rated pictures of himself as we have learned being straightforward about who the Health Educator is and his role increases trust among users (Hall et al., 2016).

In order to reach participants throughout the catchment area using GPS-based mobile apps, the Health Educator will utilize the BlueStacks App Player (software that allows users to run mobile apps on a desktop computer) as well as a mobile app (Fake GPS) that allows him to choose and set the address where he appears in GPS-based apps. By logging on to GPS-based apps such as Grindr, badoo, scruff, Jack'd, and A4A Radar on his computer and setting the address for different cities within the catchment area where participants live, he will be able to communicate via apps with participants in those cities and in a broader geographic range while working from his office at Wake Forest School of Medicine.

We are also establishing an interactive bilingual Facebook group that will be optional to intervention participants, using Facebook's secret group feature. All aspects of secret groups on Facebook are invisible to those who are not members, and only participants who are enrolled in the weCare intervention will be invited to join and admitted in to the group if they choose. Within the secret group the Health Educator will post information related to HIV care linkage, retention, and health outcomes. Posts will be in English and Spanish, and designed to be engaging, informative, and accessible. For example, graphics that illustrate the rates of MSM who are linked to care, retained in care, and have suppressed viral loads can raise consciousness among young MSM about the importance of taking action. We will include interactive polls and provide links to other reliable data sources about HIV, including low literacy articles about living with HIV, and peers (i.e., other racially and ethnically diverse young MSM who are HIV-positive) will make guest posts sharing about their lived experiences with HIV care and offering social support. We will also post and update informal and welcoming pictures and videos of clinic staff to increase the self-efficacy of participants to attend appointments.

DISCUSSION

This article describes the foundation and development of weCare, an HRSA SPNS-supported tailored social media intervention designed to improve health outcomes among a diverse group of young MSM living with HIV. There are several key aspects of the study that are critical to the anticipated success of the intervention that others can utilize in the development of similar interventions, namely: the value of the intervention's targeted, tailored, and personalized approach to supporting health outcomes for young MSM living with HIV.

INTERVENTION IS TARGETED TO DIVERSE MSM

Young MSM, particularly those of racial and ethnic minority status, face compounding stigma and discrimination making them less likely to participate in interventions where they may out themselves. Stigma and discrimination (especially for newly diagnosed individuals) and structural factors (e.g., limited transportation and work/school schedules) may challenge young HIV-positive MSM's ability and willingness to participate in more traditional interventions.

Racially and ethnically diverse young MSM have high rates of social media use, including Facebook, text messaging, and apps designed for social and sexual networking. Our utilization of existing social media platforms, allows us to meet young MSM where they are and use evidence-based and theoretically sound strategies and messages to promote health. The weCare Health Educator will engage in discussions at the pace of each user−building trust, discussing priorities related to care, providing social support, and offering guidance for overcoming barriers to care. Further, the Health Educator's role as a community insider, as well as the guidance of the steering committee, will also help to ensure that messages and communication styles are congruent with the needs of young, diverse MSM, and transparency about the Health Educator's identity and role will help to establish credibility.

THE INTERVENTION IS TAILORED BY MEDIA USED

Preliminary research indicates that the overwhelming majority of young MSM are willing to use Facebook, text messaging, and app-based instant messaging to receive sexual health information (Bachmann et al., 2013; Holloway et al., 2014; Muessig, Pike, Fowler, et al., 2013; Rhodes, 2004; Rhodes, Hergenrather, et al., 2011; Sun et al., 2015, 2016). In our MAP'T study many users contacted the health educator for information regarding disease transmission and sexual behaviors indicating that users may have a limited number of people they feel comfortable reaching out to regarding sexual health issues and are in need of credible information from a reliable source (Hall et al., 2016).

Accordingly, weCare will utilize a tailored approach where young MSM can choose their mode of connection to the health educator (e.g., the separate or combined use of Facebook, text messages, and app-based instant messaging, and of the Facebook secret group) based on personal preference and which social media platforms they use most in their daily lives; this process has led to extremely high retention rates in two of our most recent intervention studies with Latino MSM (Rhodes, Alonzo, et al., 2015; Rhodes, Daniel, et al., 2013). For example, using these three platforms, we had a 100% retention rate at 6-month follow-up in one study (U01PS001570; $N = 304$) and a 95% retention rate at 24-month follow-up in another study (R01MH087339; $N = 186$).

While there are some challenges to using apps and other forms of social media (Muessig, Pike, Legrand, et al., 2013; Sun et al., 2015), using established, popular apps might reach populations at increased risk for HIV with unique challenges to care linkage and engagement. Utilizing health educators in spaces participants choose that are familiar, comfortable, and accessible could help provide opportunities to clarify misconceptions related to HIV and help connect individuals to essential HIV-related care. Our approach combining theory, personal relationships, and social media may be especially useful for young MSM's health promotion.

THE INTERVENTION IS PERSONALIZED TO EACH PARTICIPANT'S NEEDS

There are many places across the Care Continuum that may be missed opportunities for racially and ethnically diverse young MSM to link or engage in HIV-related care which has implications for health outcomes. weCare is unique in the individualized approach for each participant based on his specific needs and context, e.g., age, developmental context, initial care linkage, medication reminders, social support and/or education (PrEP for uninfected partners). Thus, the Health Educator will tailor theory-based messages to meet the participants' individual needs and care-related goals, and adapt messages so that they are personalized to the specific questions, challenges, and successes that participants communicate to the Health Educator.

Our team recognizes that alone social media may not be enough for behavior change, highlighting the importance of developing interpersonal trust and relationships. Accordingly, weCare moves beyond information transfer and instead strives to support behavior change through social support. Much of the success of this intervention focuses on the Health Educator's ability to identify with, build trust, engage in dialogue, and offer appropriate and personalized guidance to social media users. This approach may be more appropriate than programmed responses based on entered data, particularly given that social media users are increasingly targeted by fake identities (Isaacson, 2011). Rather than supplanting the role of personal

relationships in health promotion, our intervention will use social media technology as a tool to facilitate and enhance the development of relationships more effectively and efficiently.

CONCLUSION

The disproportionate impact of HIV on young MSM, especially racial and ethnic minorities, requires the use of innovative strategies. This article describes the potential value and utility of a tailored, social media-based HIV and sexual health intervention that respects community culture and maintains an authentic approach for establishing credibility and rapport with participants. There is a clear need for interventions that connect young MSM living with HIV to resources for health promotion, including care linkage and retention, ART adherence, and viral suppression. Accordingly, weCare has important public health implications and illustrates useful ways to leverage existing social media technology for HIV-related health interventions. The social media apps are a promising platform for providing sexual health education and geographically specific HIV care referrals, offering support through the care linkage and engagement process, and improving health outcomes for young MSM living with HIV.

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