Last updated November 3, 2025

WARD 86 RAPID RESTART OF ANTIRETROVIRAL TREATMENT (ART) GUIDELINES

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WARD 86 HIV CLINIC: Ward 86, established in January 1983, is a large HIV clinic based at San Francisco General Hospital at the University of California, San Francisco (UCSF). Ward 86 serves publicly insured people with HIV within the city of San Francisco. Like many Ryan White funded clinics, the virologic suppression rate at Ward 86 of 90% is higher than the national average of 67% (CDC February 2025). However, Ward 86 has an intense focus on the 10% of people with HIV at the clinic with ongoing viremia and off of ART. The POP-UP program to serve people with HIV and who are experiencing housing insecurity was started in 2019 and this low-barrier program has improved outcomes in the homeless population (Hickey JID 2022). In late 2020, Ward 86 started a pilot program to start people with HIV off ART on ART on the same day of presentation (GTZ Provider brochure). This program is modeled after our highly successful program to start ART immediately upon a new diagnosis (Coffey JAIDS 2019) and is called the "RAPID Restart" program at Ward 86, described here (Salazar JAIDS 2025). Since most patients off ART are generally not coming to routine primary care appointments, 89% of the rapid restarts of ART from August 2020 to October 2023 occurred in the drop-in or Urgent Care clinic at Ward 86. This protocol both describes the original RAPID Restart program at Ward 86 and refinements to the clinical care program after the first pilot phase of the program to enhance success.

Purpose of this document

- Provide guidance to clinicians on RAPID Restart of ART to help increase virologic suppression rates across the U.S.
- Provide guidance to clinicians on how long-acting injectable ART is used in RAPID Restart programs
- Describe the outcomes of the pilot program of RAPID Restart at Ward 86 from 2020-2023
- Describe refinements to the RAPID Restart program made after 2023 to improve virologic suppression rates and overall outcomes

WARD 86 RAPID RESTART OF ANTIRETROVIRAL THERAPY (ART) FOR PERSONS WITH HIV IN CARE

The following details Ward 86's protocol on the immediate re-initiation or RAPID Restart of ART for people with HIV not on ART

BACKGROUND

Persons with known HIV diagnoses who are not on ART (a lapse of ≥4 weeks) often are at high risk of

HIV-related illness as well as general dis-engagement from medical care. They may benefit from immediate ART restart, but focused re-engagement efforts are likely needed thereafter to successfully engage in ongoing HIV primary care and achieve long term virologic suppression. The RAPID Restart program at Ward 86, which is modeled on the very successful RAPID program for persons with new diagnoses of HIV (Coffey JAIDS 2019), is intended to restart ART at the time of a patient's re-presentation for care, and concurrently to initiate robust and structured engagement services tiered to the patient's anticipated barriers to ongoing care.

We recently published (in November 2025, the month these guidelines were posted) the results of our pilot program of RAPID Restart at Ward 86 (Salazar JAIDS 2025). Using electronic medical record data, we conducted a retrospective study of adults with HIV in our RAPID Restart program between August 2020 and October 2023. Patients must be ≥18 years old, out of care, and self-reported to be off ART to be in the program. We examined two primary outcomes: (1) viral suppression (VS) [HIV viral load (VL) <200 copies/mL] within 180 days and (2) sustained re-engagement in care (≥1 primary care provider visit both within 90 and 91–180 days after RAPID Restart. Among 141 adults (median age 42; 85% men; 26% Latino/a), the prevalence of concomitant life challenges were common: housing instability /homelessness was 46%, substance use was 61%, and mental illness in the cohort was 49%. Among those with baseline viremia who returned for follow-up viral load, virologic suppression rates was only 58% when considering missing follow-up viral loads as nonsuppressed. Sustained re-engagement in care was observed in only 33%. Given these low rates of follow-up and virologic suppression in the RAPID Restart program, Ward 86 added a low-barrier provider and social worker-staffed model of drop-in care to follow patients who rapidly restarted ART called the Flexible Linkage to Care Expansion (FLEX) Program in November 2025

This document is intended to outline procedures for evaluating patients at the at time of their return to care (or initial presentation) at Ward 86, restarting ART (RAPID Restart), and subsequently supporting them to remain in care and achieve long-term viral suppression. This protocol also describes the Flexible Linkage to Care Expansion (FLEX) Program to provide more medical and social support for patients rapidly restarting ART at Ward 86.

Ward 86 recommends Rapid Restart for all Persons with HIV (PWH) who are off ART, provided that the

1. ART and HIV resistance history is known or can be predicted adequately (based on previous resistance testing, HIV viral load while on ART, and adherence history),
2. appropriate ART regimen can be devised without information from current resistance test results, and
3. the patient agrees to restart ART and to engage in clinical care.

RAPID restart of ART is particularly urgent for persons with CD4 counts <200 cells/mm^3.

There are *few contraindications to RAPID Restart.* These include known or suspected untreated central nervous system opportunistic infections (as for newly-diagnosed patients) and known or suspected complicated HIV resistance for which results of resistance testing would be needed in order to select an effective ART regimen.

CLINICAL CONSIDERATIONS AND RECOMMENDATIONS FOR RAPID RESTART

OVERVIEW AND CLINIC FLOW

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The RAPID Restart program at Ward 86 is intended to provide immediate medical and social services evaluation and ART restart at the patient's re-presentation for care, with initiation of structured support services directed to the patient's anticipated barriers to cares. The initial acuity of the patient in terms of both medical and social needs are estimated by the RAPID Restart Predictive Engagement (PESCO) score as defined below. The PESCO score helps triage patients rapidly starting ART into a level of acuity that helps determine the next steps in terms of the degree of medical and social support needed (e.g. lowest acuity being in Group 1 and the highest acuity being in Group 3).

Patient engagement score (PESCO) for RAPID Restart: Acuity (lowest-highest) defined by score

Criterion	2 points	1 point	0 point
Care engagement/health care utilization	Only ED or Adult Urgent Care visits in past 6 months, or no recent care engagement	No regular primary care in past 6 months but has had Ward 86 Urgent Care visit(s)	Regular Ward 86 primary care attendance in past 6 months
Housing status	On street or in shelter/navigation center	Unstably housed (eg, non-permanent SRO, couch surfing)	Stably housed (eg, own/rent or stable SRO)
Substance use	Active substance use affecting day-to-day function including adherence	Active substance use but able to function including taking medications	No substance use or in remission
Mental health	Major depression, anxiety, psychotic disorder, bipolar disorder compromising function	Mental health disorder but in treatment and able to take HIV medications	No major mental health issues
Health insurance	No insurance	Incompatible insurance (eg, out of county)	Compatible insurance
Clinical staging	Low CD4 count (known to be <200) and/or *medical issues that need addressing*	Low CD4 count (known to be <200) but clinically stable/well	CD4 count likely >200 and clinically stable

0-3: Group 1
4-7: Group 2
8-12: Group 3

Prior to November 2025, people with HIV (PWH) who were rapidly restarted on ART were seen by the PHAST/RAPID clinical team at Ward 86 and offered social supports during the 3-6 months after rapid restart of medications with the goal of reengaging the patient in ongoing HIV primary care. During this time, patients were transitioned to the usual Ward 86 primary care model or to another continuity care model, such as our program to support people with HIV and housing insecurity (e.g. POP-UP, Hickey JID 2022). Of note, low-barrier, comprehensive HIV primary care models that provide drop-in services are a promising strategy for engaging people with HIV (PWH) experiencing homelessness in longitudinal HIV care. The Positive-Health Onsite Program for Unstably Housed Populations (POP-UP) HIV primary care model at the Ward 86 clinic in San Francisco is a low-barrier approach designed to address the needs and preferences of this population. We previously reported that virologic suppression rates were improved among homeless people with HIV at our clinic via the services provided through POP-UP. However, most patients who were in the RAPID Restart program needed an intermediate level of care between HIV primary care and the intensive POP-UP program, which is why we created the FLEX program to serve the unique needs of this group.

Flexible Linkage to Care Expansion (FLEX) Program: After November 2025, a higher level of engagement with patients in the RAPID Restart program was initiated with the Flexible Linkage to Care Expansion (FLEX) Program to provide medical and social support to those recently re-initiating ART.

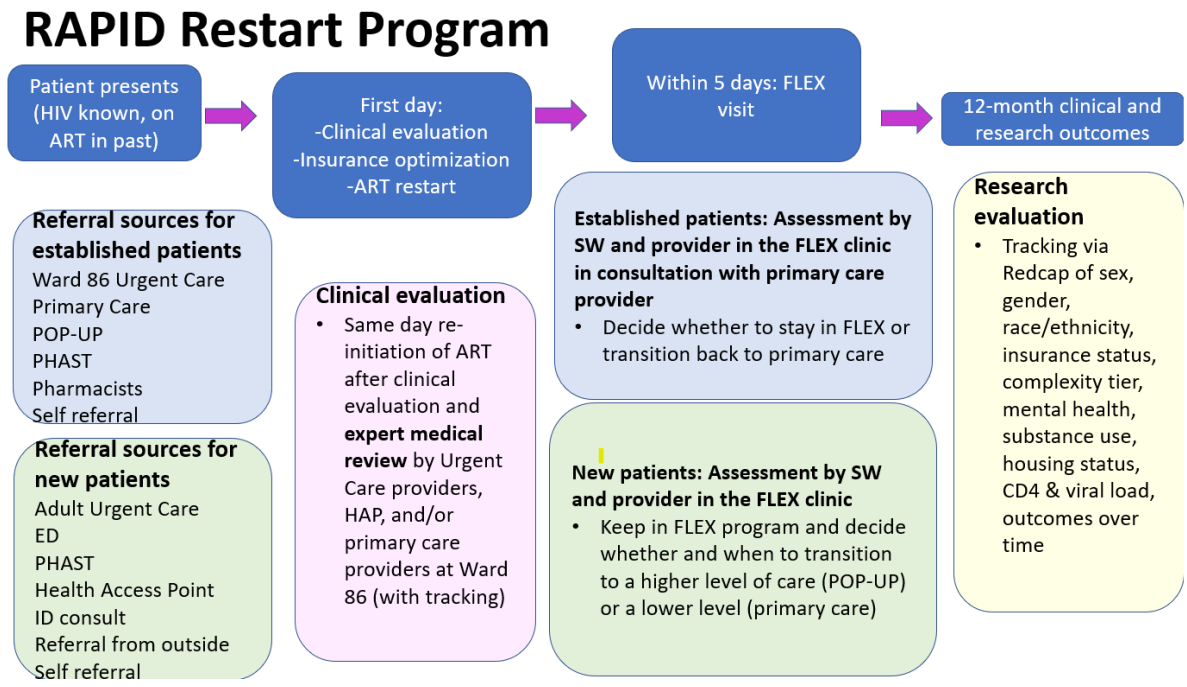
The FLEX Program at Ward 86 is a new, innovative clinical initiative developed to address key gaps in

care for people living with HIV who face psychosocial complexity and challenges with HIV care engagement. Building on insights from the RAPID Restart pilot, which revealed that only half of the patients who underwent RAPID Restart achieved and sustain viral suppression (Salazar JAIDS 2025), the FLEX Program aims to provide a supportive and adaptable level of care that bridges the gap between standard HIV primary care and the higher-intensity clinical programs such as the POP-UP Program. By offering a tailored approach, the FLEX Program is designed to meet the unique needs of patients who could benefit from more flexibility and support than traditional primary care models can provide, but who do not require the comprehensive resources of programs designed for individuals with high psychosocial complexity like the Ward 86 POP-UP program.

Through a multidisciplinary team approach, the FLEX Program provides comprehensive, patient-centered HIV care, emphasizing flexible scheduling, proactive outreach, care management, and access to mental health and substance use support. The goals of the FLEX Program are threefold: (a) bridging the gap between existing care models, (b) improving health outcomes by providing flexible and responsive support to individuals who are working on achieving and maintaining viral suppression, and (c) enhancing patient engagement through adaptable and responsive services. The FLEX program is open five days a week in the afternoon with both a designated group of HIV providers and two senior social workers to provide services. The FLEX Program is designed to meet the critical needs of patients who just restarted ART and provide the flexibility and support that they need to achieve virologic suppression. The workflow of the FLEX program is presented below.

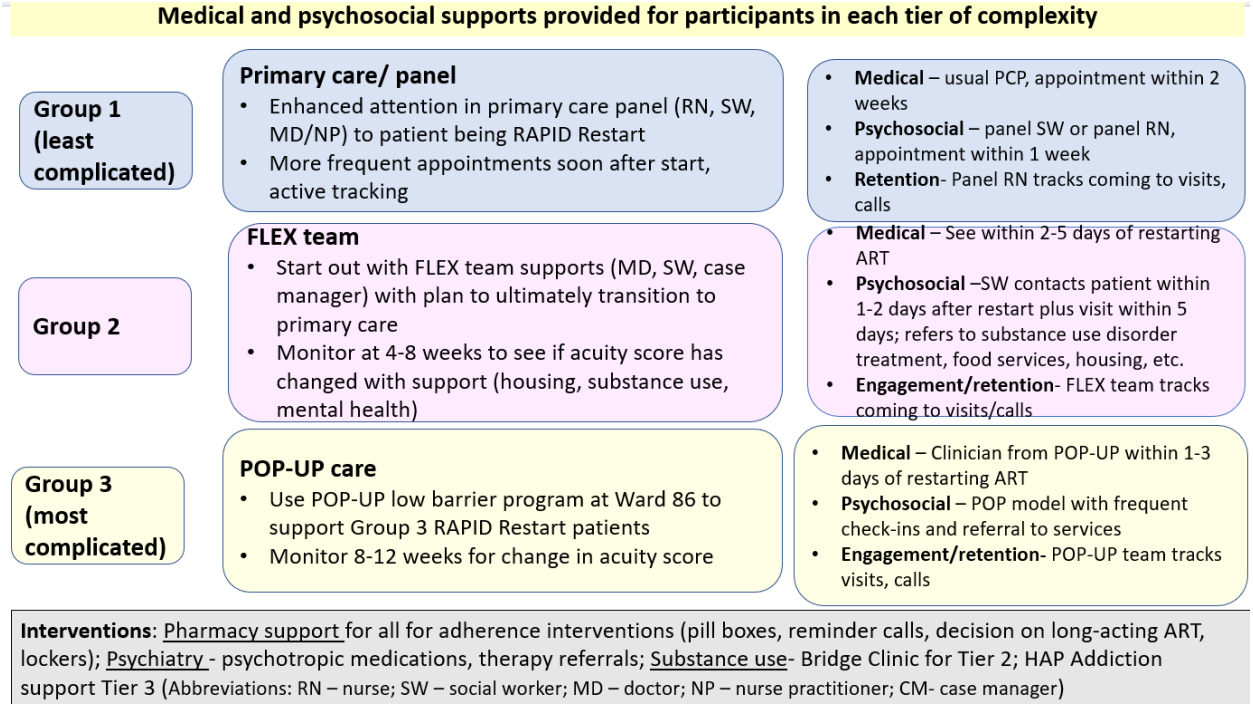
OUTLINE OF A RAPID RESTART VISIT AND SUBSEQUENT WORKFLOW, INCLUDING THROUGH THE FLEX PROGRAM

A RAPID Restart visit can be initiated by a patient or by staff who learn that a patient is off ART. Most initial RAPID Restart services are provided through the clinic's drop-in clinic (89%, Salazar JAIDS 2025) with the subsequent support of the FLEX team with the clinic workflow outlined below:



Workflow and activities

- Front Desk or other staff member notifies FLEX team of patient arrival. Of note, as per Figure below, patients in the lowest tier of complexity can be referred back to primary care and patients in the highest tier of complexity can be managed by the high-intensity POP-UP program. The FLEX team provider will decide on placement based on PESCO score and individual evaluation.
- Eligibility team will initiate or optimize insurance/benefits coverage if needed
- FLEX team will meet with patient, do initial RAPID Restart evaluation and complete the PESCO Score
- Baseline lab tests will be drawn
- Medical provider will assess patient, review HIV and ART history, select appropriate ART regimen, send prescription to pharmacy
- FLEX team will set follow up appointment for 2-5 days or less
- Social work evaluation will be made same day or within 5 days
- FLEX team clinicians and team will schedule patient frequently during the initial months of re-engagement efforts
- Other services and referrals will be provided according to PESCO score and patient's needs
- Individual treatment plans will be made by SW on the FLEX team and placed in chart
- Patients will be tracked actively, and contacted immediately if any visits are missed, with ongoing active efforts to support continuous engagement
- Follow-up HIV labs will be done per schedule (below)
- Data collection and evaluation will be done on an ongoing basis
- Patients will be evaluated continuously in the FLEX program to decide whether to escalate to a higher level of care (POP-UP) vs a lower level of care in primary care (Figure below)



For patients who do not restart immediately:

Patients who are not immediately restarted on ART (or who decline RAPID Restart) should be followed closely (e.g., in 1-2 weeks), and restarted at the earliest appropriate time.

STAFF ROLES AND MORE DETAILED PROCEDURES OF THE RAPID RESTART PROCESS

Registration and Insurance Eligibility Teams:
(For any new or returning patient with HIV who presents to the front desk and states they are not currently taking ART)

- Register patient: confirm or create patient's ZSFG medical record number and demographics/contact information.
- Confirm patient has active insurance coverage (Medi-Cal and/or Healthy SF). Call or secure chat the Eligibility team to the complete verification process or create plan for patient to obtain updated coverage immediately.
- Page (or secure chat) the FLEX team to notify the team of a RAPID Restart arrival.
- Register the patient for a drop-in visit based on FLEX team's direction
- FLEX team RN will confirm patient is off ART and the RAPID Restart Protocol will then be followed.

FLEX team RN and MD

- Room patient, complete vitals, welcome patient back to clinic
- Document using template: .**w86RAPIDRESTARTINITIATION** in EPIC.
    - Visit overview:
    - Assess:
        - HIV and treatment history
        - mental health
        - substance use
        - housing
        - income and employment
        - health goals
        - social history
    - Order and ensure completion of RAPID Restart lab work
- Complete *Rapid Restart Predictive Engagement Score (PESCO)*
    - Patients will be stratified into 3 layers of acuity/complexity for initial care management and support:
        - Group 1 - mostly HIV needs; likely primary care panel
        - Group 2 - moderate needs; likely FLEX team bridge to primary care
        - Group 3 - complex psychosocial and medical needs; likely POP UP
- Assess immediate needs
- Schedule the patient for close follow up visits as per Figure above
- Indicate that this patient is undergoing RAPID Restart, for tracking purposes and quality improvement

- Obtain patient's contact information, and provide the patient with clinic number and encourage patients to come back for follow up visits
- Fill out and obtain the patient's signature on a release of information (ROI) and fax to appropriate medical facilities to request recent records as needed.

FLEX TEAM Medical Provider evaluation and initiation of ART

Evaluation should include:

  - Review (and documentation) of HIV history (including diagnosis date, CD4 nadir, opportunistic infections (OIs), most recent CD4 and HIV RNA), ART history, history of treatment failure if any, resistance test information (baseline and subsequent), reasons for prior loss to HIV care and risk factors for future non-engagement (to include issues with insurance, housing, mental health, substance use, and medication adherence
  - Relevant PMH, allergies, medications, health related behaviors, social history
  - Focused physical exam

- Order laboratory tests
- Determine appropriate ART regimen (see *ART for Rapid Restart*, below) and send prescription to patient's pharmacy: 30-day supply + 1-2 refills*
- If not already done, engage the FLEX team RN to help with support plan and follow-up appointments.
- For tracking purposes, notify the FLEX data manager via Epic message with patient's name and MRN, and indicate that this patient is undergoing RAPID Restart.

Primary Care Provider (for Rapid Restart done during PCP appointment):

If a patient presents for a PCP appointment and reports being off ART, the primary care provider will evaluate the patient for RAPID Restart:

- Order laboratory tests as indicated
- Engage Panel RN to perform same-day RAPID Restart evaluation and PESCO score (see above), implement appropriate enhanced support plan and set follow up appointments; may involve FLEX tea
- For tracking purposes, notify FLEX data manager via Epic message with patient's name and MRN, and indicate that this patient is undergoing RAPID Restart.

Social Worker on FLEX team:

- Meet with RAPID Restart patient same day or within 1-5 days
- Evaluate immediate social services needs
- Refer for mental health and substance use treatment as indicated
- Refer for housing services as needed
- Set initial follow up appointments
- Develop individualized treatment plan and document it in Epic

Laboratory tests

At time of RAPID Restart:

- HIV RNA, CD4; HIV genotype
- HIV Ag/Ab, if record not available
- CBC + diff, CMP, lipid panel, QTF, RPR, GC/CT, pregnancy test as indicated

- Other tests as appropriate (eg, if no records): HAV IgG, HBsAb, HBsAb, HBcAb, HCV Ab, HLA B5701
- Consider serum cryptococcal antigen (CrAg) and toxoplasma IgG if CD4 is thought to be low

Follow up HIV RNA monitoring:

- 1 month after ART restart, then monthly until suppressed
- 12 weeks
- 24 weeks

ART FOR RAPID RESTART

ART regimens should be selected on an individual basis, and in consultation with an expert HIV clinician.

ART can be modified, if indicated, when results of resistance tests and past treatment history are available (eg, to another oral regimen or to a long-acting injectable ART regimen, if appropriate).

Resistance testing (generally a genotype) should be obtained at the time of RAPID Restart, unless acquired resistance is unlikely. Resistance testing may not be needed for patients who had viral suppression while last taking oral ART and who did not take ARVs intermittently before stopping (however, it should be done for anyone previously on a long-acting ART regimen (Note that resistance tests results may not detect existing resistance mutations in persons who are not currently taking ART).

We always restart patients on an oral ARV regimen as we obtain baseline laboratory results and past medical records, and as we assess patients' ability to engage in ongoing HIV care. For appropriate patients, we can do expedited starts of long-acting injectable ART after care is established.

Common scenarios for prescribers:

- The patient was taking a 1st or 2nd ART regimen and there is no suspected resistance (no baseline or subsequent resistance, no history of treatment failure, good adherence to the previous regimen and stopped it abruptly): can start one of the recommended RAPID regimens for people with new HIV diagnoses (eg, bictegravir/TAF/FTC or darunavir/cobicistat/TAF/FTC) or (unless contraindications) can restart the patient's previous regimen.
- The patient has a virus with known or suspected ART resistance mutations, history of virologic failure, previous adherence challenges or intermittent ART: select the ART regimen based on known or suspected resistance mutations, consider an augmented regimen.
    - If there is concern for NRTI and/or NNRTI resistance, we may start a boosted protease inhibitor + 2 NRTIs +/- an integrase inhibitor (eg, darunavir/cobicistat/TAF/FTC +/- dolutegravir).
    - If there is concern for NRTI and/or INSTI resistance, we may start a boosted protease inhibitor + 2 NRTIs +/- a 2nd generation NNRTI (if no history of treatment with an NNRTI) (eg, darunavir/cobicistat/TAF/FTC + doravirine).
- If the patient was taking long-acting injectable ART (eg, cabotegravir/rilpivirine), we would start an oral regimen comprised of boosted protease inhibitor + a combination of other ARVs likely to be active, pending results of resistance testing.

- Ward 86 HIV specialists are available for consultation about ART selection if needed

Send ARV prescriptions to the patient's pharmacy: 30 days with 1-2 refills (note: 5-day starter packs of BIC/TAF/FTC or DRV/c/TAF/FTC may be available, if needed – check with Ward 86 Pharmacist.)

RESPONSE TO MISSED VISITS

FLEX TEAM SW, or coordinator contacts pt within 1 day to check in, check ART adherence, address immediate needs, reset appointment, and encourage attendance. If patient is consistently not able to attend appointments, reevaluate for higher level of support, including case management, navigation, and referral to POP-UP if appropriate.

ONGOING FOLLOW-UP OF RAPID RESTART PROGRAM PARTICIPANTS

The FLEX team will do active outreach for each patient for 3-6 months after RAPID Restart, until they have transitioned to an ongoing model of care (eg, Ward 86 primary care, POP UP, or an outside primary care clinic)

- Patients who not come to follow up visits and do not respond to outreach calls for 12 weeks will be considered lost to follow up, and active outreach will be halted
- Patients will be monitored for 6 months after RAPID Restart
- Active patients will be included on "RR active follow up EPIC list" – to be used for ongoing monitoring and management
- Documentation will be conducted in Epic using smartphrases
- Weekly case conference review of patients of the previous 2 months, and any patients of concern
- Monthly review RR patients of previous 3-6 months, including monitoring of appointments attended/missed, contacts with patient, services rendered, and HIV RNA results
- FLEX team RN/care coordinator contacts patients who have missed follow-up visits, resets appts, offers supports and referrals as indicated
- Lost to follow up: Patients with no team contact for 1 month - RN contacts listed pharmacy to verify last medication pick up, refers for navigation if indicated
- Lost to follow up: Patients with no visits/unreachable by team for more than 12 weeks- add patient to "RR lost to f/U EPIC list" and document in EPIC: .**w86RRLTFU**

DOCUMENTATION AND TRACKING

Documentation will be conducted in Epic using smartphrases

• A list of RAPID Restart patients will be maintained in Epic for ongoing monitoring and management

- Once a week, the RAPID Restart team will review RR patients of the previous 2 months and identify and outreach to persons who have missed follow visits

• Once a month, the RAPID Restart team will clinically review patients, including monitoring appointments attended/missed, contacts with patient, HIV RNA results, services rendered. They will

contact persons who have missed appointments and offer engagement supports as indicated.

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