

HIV Infection and AIDS

1. DISEASE REPORTING

A. Purpose of Reporting and Surveillance

1. To identify new cases of HIV infection and AIDS.
2. To accurately monitor the HIV epidemic in Oregon.
3. To describe affected persons.
4. To plan and evaluate treatment and prevention programs.
5. To identify affected persons in need of services and direct them to available services.
6. To advise affected persons of means of preventing transmission of HIV to others.
7. To identify localized clusters of new infection and prevent further transmission of disease.
8. To insure that persons who have been significantly exposed to a case (e.g., sexual contacts, others exposed to blood or body fluids, injection drug use partners) and may be unaware of their exposure are counseled about measures to prevent infection.

B. Laboratory and Physician Reporting Requirements

1. Physicians and other health care providers must report a case or suspected case within one working day to the Local Public Health Authority (LPHA) (OAR 333-018-0015). Upon agreement between the Local Public Health Authority and the Oregon State Public Health Division, HIV/STD/TB Section (HST) (OAR 333-018-0005), reports may be made directly to HST (OAR 333-018-0005).
2. Licensed laboratories must report to the LPHA within one working day results of all tests indicative of and specific for HIV infection (e.g., detectable levels of HIV ribonucleic acid [RNA], positive tests for p24 antigen, positive enzyme linked antibody (EIA) tests for HIV when confirmed by Western Blot, CD4+ T-lymphocyte counts < 200 cells per microliter or 14% of T-lymphocytes) (OAR 333-018-0015). Upon agreement between the LPHA and the Oregon State Public Health Division (HST) (OAR 333-018-0005), reports may be made directly to HST (OAR 333-018-0005). In addition, licensed laboratories must report results of all CD4 + T-lymphocyte counts and viral RNA tests ("viral loads") regardless of result within seven days. Laboratory reports may be made directly to the Oregon State Public Health HIV/STD/TB Program (OAR 333-018-0015).

C. Local Public Health Authority Reporting and Follow-Up Responsibilities

1. LPHA must report all confirmed cases of HIV infection and AIDS to HST no later than the end of the business week of the initial report by the laboratory, physician or other health care provider. (OAR 333-018-0020).

2. THE DISEASE AND ITS EPIDEMIOLOGY

A. Etiologic Agent:

Human immunodeficiency virus-1 (HIV-1), a retrovirus, is the cause of almost all HIV-related disease in the U.S., and is found throughout the world. HIV-2 is a closely related virus, causing similar illness. To date, most HIV-2 infections have been documented in West African natives or their contacts; only a handful have been reported in the U.S.

B. Description of Illness

Untreated illness due to HIV infection is biphasic. The initial phase, which may go unnoticed, occurs shortly after infection. This acute syndrome resolves spontaneously, and the infection becomes latent for

several years. Eventually, if untreated, a progressive immune dysfunction develops, associated with depletion of CD4+T-lymphocytes, which predisposes the affected individual to opportunistic infections, tumors, and other conditions.

1. Acute Infection

Shortly after exposure, many infected persons experience a flu-like illness that may resemble mononucleosis. Onset is typically abrupt. Common symptoms of acute infection include fever or sweats, myalgias or arthralgias, malaise and lethargy, lymphadenopathy, sore throat, anorexia, nausea and vomiting, headaches, photophobia, rash, and diarrhea. Symptoms usually resolve over two to three weeks.

2. Subsequent Illness

Most infected persons remain asymptomatic for years after resolution of acute symptoms. During this latent period infection can only be determined by antibody, viral load, or other laboratory testing. If untreated, most HIV-infected individuals eventually manifest myriad signs and symptoms that reflect progressive immune deficiency and herald the onset of the Acquired Immune Deficiency Syndrome (AIDS) such as persistent generalized lymphadenopathy, neurological disorders, opportunistic infections (OIs), and malignancies. However treatment with antiretroviral medications (ART) can delay or reverse the progression of immune deficiency. Prior to the availability of effective (ART), the case fatality rate for AIDS approached 100%, and most patients who developed clinical AIDS died within 2 years. Many of the more common manifestations of advanced immunosuppression associated with HIV-infection are listed in the AIDS case definition (§3A).

C. Reservoir

Infected humans only.

D. Modes of Transmission

HIV transmission occurs when blood, blood products, semen, vaginal fluids or breast milk from an infected person enters the bloodstream of another person via injection or across breaks or small abrasions of the skin or mucous membranes (e.g., the eye, mouth, vagina or rectum). Virtually all transmission occurs through sexual (sex with an infected person), parenteral (injection with contaminated equipment or injection of contaminated blood or blood products), or vertical (passage of HIV from a woman to her child during pregnancy or breast feeding) route. While HIV may also be found in cerebrospinal fluid, tears, amniotic fluid, urine and bronchoalveolar fluid of infected persons, transmission via exposure to these fluids has not been documented. HIV is not transmitted by casual contact.

E. Incubation period

When present, symptoms of acute HIV infection (B.1.) occur 6 days–6 weeks (rarely, up to 6 months) after infection. HIV antibodies usually develop within a few weeks of exposure—rarely, as much as 6 months later. The interval between infection and antibody development is referred to as the “window period.” About 50% of untreated, HIV-infected persons develop AIDS within 10 years of infection; AIDS is rare within 3 years of initial infection.

F. Period of Communicability

HIV-infected persons are infectious for life, although the relative infectivity may vary considerably over time.

G. Treatment

Specific treatment of HIV infection and AIDS is complex and beyond the scope of these guidelines. (Treatment guidelines can be found at <http://aidsinfo.nih.gov/guidelines/>.) Decisions about when to start ART and OI prophylaxis depend on clinical status and laboratory markers (such as CD4+ T-lymphocyte [CD4] counts). Health care providers can obtain treatment advice from the OHSU Consult

Service (in Portland, 503-494-4567; elsewhere, 800-245-6478), from the Research and Education Group (in Portland, 503 229 8428; elsewhere, 800 875 8428)

Be aware that effective treatment reduces or suppresses viral replication and greatly reduces the risk of transmission. All patients with HIV should be referred for treatment. ART in pregnancy and during labor reduces the risk of vertical transmission of HIV at birth from mother to infant. Elective cesarean delivery may further reduce vertical transmission in cases where plasma levels of HIV RNA are not sufficiently suppressed (<1000 copies/ml) prior to the onset of labor. Breastfeeding by HIV-infected women is not recommended in the U.S.

Additional medications can prevent opportunistic infections (OIs) such as disseminated *Mycobacterium avium* complex and *Pneumocystis* pneumonia in the presence of advanced immune deficiency. Antiretroviral drugs in current use include nucleoside and non-nucleoside reverse transcriptase inhibitors, protease inhibitors, integrase inhibitors, CCR5 binding inhibitors and fusion inhibitors.

3. CASE DEFINITIONS, DIAGNOSIS, AND LABORATORY SERVICES

In Oregon, newly diagnosed cases of HIV infection, regardless of severity must be reported to local or state public health authorities (ORS 433.004 and OAR 333-018-0000, 333-018-0010, 333-018-0005, 333-018-0015, 333-018-0030, 333-019-031)

A. Confirmed Case

1. Persons aged ≥ 18 months

A multi-test algorithm consisting of a positive result on an initial serologic test, which may be an HIV antibody test or a combination HIV antigen/antibody test followed by a positive result on an HIV test different from the initial test, as recommended by the Clinical and Laboratory Standards Institute (CLSI) in the Criteria for Laboratory Testing and Diagnosis of Human Immunodeficiency Virus Infection: Approved Guideline [CLSI document M53-A, ISBN 1-56238-758-8], published in June 2011. The initial HIV serologic test and the other or “supplemental” HIV antibody test that is used to verify the result of the initial test may be of any type approved by the federal Food and Drug Administration for screening or diagnosis of HIV infection, but they must not be identical (FDA website:

<http://www.fda.gov/BiologicsBloodVaccines/BloodBloodProducts/ApprovedProducts/LicensedProductsBLAs/BloodDonorScreening/InfectiousDisease/UCM080466>). The type of HIV antibody test that verifies the initial test may be one formerly used only as an initial or preliminary test (e.g., as a conventional enzyme immunoassay [EIA], rapid immunoassay (IA), chemiluminescent assay, HIV-1/2 type-differentiating immunoassay), or it may be one traditionally used as a supplemental test for confirmation (e.g., Western blot [WB], immunofluorescence assay [IFA]). For the purpose of HIV infection surveillance, the CLSI algorithms that conclude with a “presumptive positive” are to be considered equivalent to those that conclude with a definitive positive.

OR,

Positive conclusion of a multi-test HIV antibody algorithm from which only the final result was reported (including a single positive test result from a “supplemental” test (e.g., HIV Western blot, immunofluorescence assay)

OR,

Positive result or report of a detectable quantity (i.e., within the established limits of the laboratory test) from any of the following HIV virologic (i.e., non-antibody) tests:

- Qualitative HIV nucleic acid (DNA or RNA) test (NAT) (e.g., polymerase chain reaction [PCR])
- Quantitative HIV NAT (viral load assay)
- HIV p24 antigen test
- HIV isolation (viral culture)

2. Persons aged <18 months

Positive results on two separate specimens (not including cord blood) from one or more of the following HIV virologic (non-antibody) tests:

- HIV nucleic acid (DNA or RNA) detection
- HIV p24 antigen test, including neutralization assay, for a child aged >1 month
- HIV isolation (viral culture)
- HIV genotype nucleotide sequence

B. Suspect Case

1. Persons aged ≥18 months

Unconfirmed positive antibody or antigen test such as rapid or laboratory-based test without evidence of confirmation or a positive combination antigen antibody test with a negative second antibody test of a different brand or type (such as a Multispot® or Western Blot test)

OR,

A note written by a physician or other qualified medical-care provider that does not meet the laboratory criteria described above but states that the patient has HIV infection.

OR,

Evidence of testing by licensed health care provider for any of the following: HIV nucleic acid (DNA or RNA) detection (a.k.a. “viral load”); HIV p24 antigen test; HIV isolation (viral culture); CD4+T-lymphocyte count or percentage of total lymphocytes; antiretroviral resistance testing.

2. Persons aged <18 months

Positive results on only one specimen (not including cord blood) from any of following HIV virologic tests

- HIV nucleic acid (DNA or RNA) detection
- HIV p24 antigen test, including neutralization assay, for a child aged >1 month
- HIV isolation (viral culture)
- HIV genotype nucleotide sequence

AND,

No subsequent negative results on HIV virologic or HIV antibody tests

OR,

A note written by a physician or other qualified medical-care provider that does not meet the laboratory criteria described above but states that the patient has HIV infection.

C. Staging

Staging categories are intended for public health surveillance and prevention of transmission and not as a guide for clinical diagnosis, patient management, or qualification for benefits. To distinguish the stages of HIV disease defined in this document for surveillance from stages defined for clinical management or other purposes, they should be called "Surveillance Stages." In Orpheus, state (HST) staff will assign each new HIV infection to one of five stages (stage 0, stage 1, stage 2, stage 3, or stage unknown) at the time of diagnosis. Stages 1, 2, and 3 are based primarily on the CD4+ T-lymphocyte count. Although the stage at diagnosis does not change, if >180 days have elapsed after diagnosis in Stage 0, the stage at the later date is classified as 1, 2, 3, or Unknown, depending on CD4+ T-lymphocyte test results on that later date (or within 3 months of it), as described below. Children (aged <13 years) can be classified as Stage 0 if they are known not to have acquired infection through vertical transmission (perinatally from the mother). Children with laboratory evidence of HIV infection and evidence of a qualifying opportunistic illness can be classified as Stage 3 as defined below. CD4 counts should not be used to stage cases in children because no consensus exists about the appropriate levels of CD4 counts for classification. Therefore children who cannot be classified as Stage 0 or Stage 3 will be classified as Stage "undefined."

The stages are defined as follows:

1. Stage 0

Stage 0 is intended to identify people with acute or recent HIV infection. It is defined either by the relationship between positive and prior negative HIV test dates or by a testing algorithm that detects early HIV infection prospectively. It is independent of CD4+ T-lymphocyte test results. A "test date" means the date on which the specimen for the test was obtained, if known, not necessarily the date on which the test was conducted. The stage is 0 if the following criteria are met:

- The date of a negative or indeterminate HIV test was 1 to 180 days before the date of the first confirmed positive HIV test.
- OR,
- The date of a negative or indeterminate HIV antibody test was 0 to 30 days after the date of the first confirmed positive HIV test.
- AND,
- The negative or indeterminate antibody test was less sensitive than the first confirmed positive HIV test (based on the test sensitivity ranking listed below).

Exceptions: A confirmed case of HIV infection is not Stage 0 if any of the following are true:

- The negative or indeterminate HIV test used as the criterion for the earliness of infection was preceded by >60 days by evidence of an earlier onset of HIV infection: an HIV infection diagnosis based on a clinical ("physician-documented") diagnosis, a CD4 T-lymphocyte count <200 cells/ μ L in an adult/adolescent, or a Stage-3-defining opportunistic illness as stated in the 2008 case definition [1])
- If the criteria for Stage 0 are not met at diagnosis, the stage is classified as 1, 2, 3, or Unknown, depending on the CD4+ T-lymphocyte test results at diagnosis (or within 3 months of diagnosis), as described below.

2. Stage 1

- Criteria for Stage 0 not met
- AND,
- CD4 count of >500 cells/ μ L

OR,

- If CD4 count is unknown, a CD4+ T-lymphocyte percentage of total lymphocytes of >29%.*

3. Stage 2

- Criteria for Stage 0 not met
- OR,
- CD4 count of 200--499 cells/ μ L or
- OR,
- If CD4 count is unknown, a CD4 percentage of 14%--26.1

4. Stage 3

- Criteria for Stage 0 not met
- AND,
- At least one of the following:
 - ♦ CD4 count of <200 cells/ μ L or
- OR,
- ♦ If CD4 count is unknown, a CD4 percentage of <14%
- OR,
- ♦ One or more of the following at the time of staging. (Whatever method was used to make the diagnosis of any of the opportunistic illnesses will be accepted as sufficient.)
 - ✦ Candidiasis of esophagus, bronchi, trachea, or lungs;
 - ✦ Cervical cancer, invasive in persons aged ≥ 13 years;
 - ✦ Coccidiomycosis, disseminated or extrapulmonary;
 - ✦ Cryptococcosis, extrapulmonary;
 - ✦ Cryptosporidiosis, chronic intestinal >1 month duration;
 - ✦ Cytomegalovirus disease (other than liver, spleen, or nodes) in persons aged >1 month;
 - ✦ Encephalopathy, HIV-related;
 - ✦ Herpes simplex ulcer(s) > 1 month duration, bronchitis, pneumonitis, or esophagitis in persons aged >1 month;
 - ✦ Histoplasmosis, disseminated or extrapulmonary;
 - ✦ Isosporiasis, chronic intestinal >1 month duration;
 - ✦ Kaposi's sarcoma;
 - ✦ Lymphoma, Burkett's (or equivalent term);
 - ✦ Lymphoma, immunoblastic (or equivalent term);
 - ✦ Lymphoma, primary, of brain;
 - ✦ *Mycobacterium avium* complex or *M. kansasii*, disseminated or extrapulmonary;
 - ✦ *Mycobacterium tuberculosis*, pulmonary or extrapulmonary;
 - ✦ *Mycobacterium*, other species or unidentified species, disseminated or extrapulmonary;
 - ✦ Pneumocystis pneumonia;
 - ✦ Pneumonia, recurrent;

* The change in the CD4 percentage threshold from 29% (as in the current case definition) to 26% (as in the revision proposed above) should be contingent on data being published that support it.

- ✦ Progressive multifocal leukoencephalopathy;
- ✦ Salmonella septicemia, recurrent;
- ✦ Toxoplasmosis of brain in persons aged >1 month;
- ✦ Wasting syndrome due to HIV;
- ✦ (Multiple or recurrent serious bacterial infections.) Any combination of at least two culture-confirmed infections within a 2-year period of the following types in persons aged ≤1 month: septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media, superficial skin or mucosal abscesses, and indwelling catheter-related infections.)

5. Stage Unknown

- Criteria for Stage 0 not met
- AND,
- No information available on CD4+ T-lymphocyte count or percentage
- AND,
- No current evidence of opportunistic illness among those listed above (§3BC4).

C. Services Available at the Oregon State Public Health Laboratories (OSPHL)

OSPHL tests serum and oral specimens for HIV antibodies by an assay that detects both P24 viral antigen and HIV antibody. This is known as a “4th generation” HIV screening test. Positive samples are tested by a second test, either a Multispot® (another type of antibody test that distinguishes HIV 1 from HIV 2) or a Western Blot test. For HIV testing, 5-7 ml of blood in a 13x100 Vacutainer® tube is required. Contact the virology section at OSPHL (503-693-4100) or the state HIV Program (971-673-0181) with questions about HIV testing. HIV testing at OSPHL is available to LPHA clients and to others by special arrangement with OSPHL and the HIV Prevention Program.† OSPHL does not offer rapid antibody testing, HIV RNA detection (a.k.a. “viral load”), HIV isolation (viral culture), or testing for resistance to antiretroviral drugs.

D. Other Laboratory Methods (Not Available at OSPHL)

Rapid testing can be obtained from some LPHA’s and private health care providers. Other HIV-related tests can be obtained from private providers or clinical labs.

4. ROUTINE CASE INVESTIGATION

A. Case Investigation

1. Primary Investigation by Local Public Health Authority

New suspect, and confirmed HIV and AIDS cases may be identified by the LPHA through a direct report from a physician or from a laboratory report of a confirmed positive HIV test (serologic or antigen) (§3A) or positive HIV viral load in an individual whose case has not previously been reported. Cases may also be reported to the LPHA by HST as a result of direct

† Until February 2012, a person could not be tested for HIV in Oregon unless he or she provided informed consent in a strict medico-legal sense. With the passage of SB 1507 in February 2012, a person upon whom HIV testing is being conducted must be notified of the intent to test for HIV and given an opportunity to decline testing. Notification may be conducted verbally or in writing and may be contained in a general medical consent for treatment.

reporting by laboratories or physicians or as a result of required laboratory reporting directly to HST of all viral loads and CD4+ T-lymphocyte tests and percents (See §1B2).

a. Confirmed Case (See §3A)

- i. Verify that the case has not been previously reported. If the case has previously been reported no additional investigation is required. If you have reason to suspect that the case is not engaged in regular medical care with an HIV specialist (e.g., the reporting provider is not an HIV specialist) attempt to contact the case and/or the health care provider to offer referral to an HIV care specialist. A list of case management specialists who can assist with referrals to care in every county can be found at the following website:
<http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Pages/cmcontacts.aspx>
- ii. **Completing the Case Report** (*If case not previously reported.*) Contact the facility/s or health care provider/s where the diagnosis was made and any medical treatment rendered. Paper case report forms can be faxed securely and completed by the provider or completed by the local health department via an interview with the provider or someone from his or her staff. (See Appendix 1 for a printable case report form and instructions.) A supplemental case report form should be completed for each new facility or provider from which data are obtained. Transfer the information from the completed paper report form into Orpheus. If you are completing the case report via telephone, you can enter the information directly into Orpheus without completing a paper case report form. After the case report information has been entered into Orpheus, the paper form can be destroyed. If it is necessary to contact multiple facilities where treatment was rendered, make a notation of this fact in the area reserved for notes in the Orpheus case report. Supplemental case reports collected from additional providers or facilities or from cases themselves need only record clinical, social or demographic information not collected on the initial report and any information that contradicts that collected on an earlier report. It is not uncommon for one local health authority to receive a laboratory report for someone who is ultimately determined to live in another county. This often happens when a clinical laboratory doesn't know the county of residence of the patient and supplies the county where the provider or laboratory is located instead. If you happen to make contact with a medical provider or facility, only to learn that the case doesn't reside in your county, please make an effort to collect the information necessary to complete the case report on behalf of your colleagues. This saves time and aggravation for everyone involved. After completing the report, transfer the case in Orpheus and make a courtesy call to colleagues in the county of residence of the case to advise them of the new case.
- iii. **Interviewing the Patient**
 1. Advise the physician or other regular health care provider that someone from public health will likely contact the patient (or parent or guardian if the patient is aged <13 years) to collect information and verify the case report data including demographics and exposure categories, and to offer assistance with notification of partners and referral to available health and social services. In some instances, the newly reported case might represent a prevalent case that has not previously been reported to public health. Such a patient might have been aware of the infection and receiving medical treatment for a long time. If this circumstance arises, advise the provider that the reason the case is being investigated now is that a record search indicates that the case had not previously been reported.

2. Newly-diagnosed HIV cases should be interviewed to (1) identify sex partners and others at risk for testing and counseling to reduce their own risk of infection, and (2) assure the case has been referred for medical and social services. Early medical intervention prolongs survival and reduces risk of transmission.
 3. Interview the case following the Patient Interview Form and Instructions (Appendix 2), then enter the information in the appropriate areas of the “Basic,” “Risk” and “Clinical” tabs of the Orpheus case report. If the patient provides “Basic” or “Risk” information that contradicts information collected from health care provider/s, overwrite the provider response with the patient response and make a note of the change in the notes section of the Orpheus case report. (In cases where the patient is aged <13 years, speak with the parent or legal guardian first. Exercise professional judgment about the need to interview the child separately or in the presence of the parent or guardian.)
 4. During the case interview, ask the case to identify individuals at risk of infection (contacts) and develop a plan for notification and testing of contacts. A contact form should be completed for each named contact (Appendix 2). Individuals at risk include any sex partners within the previous year, or people with whom the case might have shared injection drug use equipment. Ideally, notification of contacts should be done by the LPHD. If the case prefers to notify contacts him(her)self, the LPHD should make arrangements to follow-up with the case to verify that those contacts have been notified. Sometimes hybrid approaches are successful such as making plans with the case to co-notify. For example, the case tells the partner to expect a call from the local health department to offer services and information. Motivational interview techniques, including role playing with the case the response of the partner can help the case feel competent to handle the conversation. Record the date of the case interview and the names and other identifying information in the contact section of the Orpheus case in addition to the details of any medical referrals (follow-up tab).
- iv. LPHA’s may not have available staff that is specifically trained to interview HIV cases for the purpose of identifying sexual partners and other at-risk contacts. Oregon Health Authority, HIV and STD Program (HST) staff are available for consultation about HIV case interviews and follow-up. In special circumstances, HST can conduct the interview at the request of the local public health authority. These circumstances might include high priority infections such as new infections in pregnant women, evidence of a cluster. In some cases, the health care provider may indicate that he/she would like to advise the patient of the impending contact by the LPHA Generally LPHA should not contact the patient prior to advising the health care provider. This is a matter of professional courtesy. In addition, on occasion, the case might not yet have been notified of the infection. Receiving this information from the LPHA might be awkward, at the least. Rarely, a medical provider may believe that direct contact by a public health representative would be detrimental to the health or well-being of patient or his contacts. Such instances should be noted in the comments section of the case report from and discussed with the HIV Surveillance Program (971-673-0153)
 - v. If you used a paper case report form rather than completing the case report online, send the completed case report form to HST HIV Data and Analysis Program by secure fax (971-673-0179) or by secure file transfer protocol or other secure transmission methods. To arrange for alternate forms of secure data transmission, call the HIV Data and Analysis Program at 971-673-0183.

b. Suspect Case (See §3B)

- i. Contact the patient’s physician(s) and/or reporting laboratory to determine whether laboratory confirmation of HIV infection has ever been collected from this patient. Advise the physician or other regular health care provider that laboratory testing history suggests that the patient may have a case of HIV infection or AIDS and a record search indicates that the case has not previously been reported. If laboratory evidence of HIV infection is verified (See §3A), the case may be called confirmed and should be investigated as in §4A1. If laboratory confirmation of infection cannot be verified, no additional investigation is necessary.

5. CONTROLLING FURTHER SPREAD

A. Patient/Household Education

If the patient is not receiving HIV related medical or supportive services, refer the patient to a case management resource. Case managers can provide support and access to a variety of HIV related services including medical care, health insurance, prescription drugs, dental care, mental health and substance use treatment, risk reduction and treatment adherence counseling, housing, transportation, food and utility assistance. Case management services are available in every county.

1. Case management resources:

Portland Metro area

Counties	Agency	Phone	Email/Website
Clackamas, Columbia, Multnomah, Washington, and Yamhill counties in Oregon, and Clark County in Washington	Cascade AIDS Project	(503) 223-2437, (800) 777-2437, (800) 499-6940 en español	www.oregonaidshotline.com/

Balance of State (all counties outside of the Metropolitan area)

Counties	Agency	Phone	Email/Website
Coos, Curry, Douglas, Jackson, Josephine, Klamath, Lake, Lane, Lincoln Marion,	HIV Alliance	(541) 342-5088 1-866-470-3419	www.hivalliance.org
Baker, Gilliam, Grant, Harney, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, Wheeler	EOCIL	(541) 889-3119	www.eocil.org
Linn/Benton	Linn County Dept of Health	(541) 967-3888	
Clatsop	Clatsop County Health and Human Services	(503) 325-8500	
Crook	Crook County Health Department	(541) 447-5165	
Deschutes	Deschutes County Health Department	(541) 322-7400	
Hood River	Hood River County Health Department	(541) 386-1115	
Jefferson	Jefferson County Health Department	(541) 475-4456	
Polk	Polk County Health Dept.	(503) 623-8175	
Tillamook	Tillamook County Health Office	(503) 842-3900	

2. Other statewide resources

- Oregon AIDS/STD Hotline (English: 800-777-2347; Spanish: 800-449-6940)
- CAREAssist(Oregon’s AIDS Drugs Assistance Program) helps people living with HIV pay for medical care expenses, insurance, medical visits and prescription medications. (971-673-0144, www.healthoregon.org/careassist)
- The Oregon Helpline provides crisis intervention and referral to substance use and mental health treatment. Oregon Helpline (1-800-923-4357). Available 24 hours a day, 7 days a week.

3. Unusual cases such as transfusion, transplant, or hemophilia-associated disease; cases with

occupational exposure or cases with no identified risks should be discussed with HST Epidemiologists (971-673-0153).

B. Isolation of Case

Not applicable unless otherwise indicated for specific infections that occur in patients with AIDS.

C. Occupational Restrictions

None. The Americans with Disabilities Act prohibits workplace discrimination against HIV-infected individuals.

D. Restrictions on Household Contacts

None.

E. Protection of Contacts

1. Offer assistance with notification and referrals of partner. If the patient desires assistance with partner counseling (notification) and referral, refer to LPHA disease investigation specialist (DIS) or to State DIS Services (971-673-0157). Sexual and/or drug sharing partners of case-patients should be offered HIV testing and counseling to reduce risk of infection. Request assistance from local health department DIS or State DIS Services when case-patients have anonymous sex contacts (e.g. internet sex seekers) who may be challenging to contact.
2. Patients and their sex or drug sharing partners should be counseled about the ways that HIV can be transmitted including through sex, sharing of drug injection equipment, from pregnant woman to fetus or newborn infant, and by transfusion or transplant of blood or tissue.
3. HIV-infected patients should not share needles or drug supplies with others or engage in unprotected oral, vaginal or anal sex. A new, intact, latex condom should be used for each act of oral, vaginal, or anal sex between the patient and a partner.
4. Patients and their sexual or needle sharing partners should not donate blood, plasma, organs for transplantation, tissues, cells, semen for artificial insemination, or breast milk for human milk banks.
5. Universal precautions should be observed for all patients in health care settings and by household contacts who may come into contact with blood or body fluids of the patient. (Universal Precautions for Prevention of Transmission of HIV and Other Bloodborne Infections. Centers for Disease Control and Prevention. 1996. (Available at http://www.cdc.gov/ncidod/dhqp/bp_universal_precautions.html). These include:
 - a) Use of gloves, gowns, masks, and other protective barriers to prevent skin and mucous membrane exposure during contact with any patient's blood or body fluids.
 - b) Precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles

should not be recapped by hand, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal. The puncture-resistant containers should be located as close as practical to the use area. All reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.

F. Environmental Measures

Surfaces or items contaminated with blood, body fluids or excretions or secretions visibly contaminated with blood should be cleaned with 10% bleach solution.

6. SPECIAL SITUATIONS

A. Case has been a Blood or other Tissue Donor

If a reported case has donated blood, plasma, sperm, tissue or other body organs since 1978, obtain details of all donations, including date(s), type(s), and site(s) of donation. Verify that recipient agency (e.g., the Red Cross) has been informed. Enter the details in Orpheus using the notes section associated with the case.

B. Case has been Convicted of a Sex Crime

1. Obtain information on circumstances of exposure from court records and prosecuting district attorney. Based on information obtained assess whether HIV transmission was possible.
2. Review internal program guidelines and consult with program manager regarding next steps. If the case involves children under the age of 18 years at the likely time of exposure, consult with program manager regarding the need to report the case to the Children's Services Division. Consult with HST staff before notifying victims. If the case involves child molestation, Children's Services Division will need to be involved.

C. Case has Un-notified Sex Partners or Other At-risk Contacts

Optimally, notification of sex partners and other at-risk contacts will be done with the full knowledge and collaboration of the source case. As noted above (§4A1.iv), newly-diagnosed HIV cases should be interviewed to identify sex partners and others at risk for testing and counseling to reduce their own risk of infection, and (§4A1.iv) a plan should be developed for notification and testing of contacts. Other than the responsibility to investigate and control communicable disease according to "procedures outlined in the Authority's Investigative Guidelines" (OAR 333-019-0000), Oregon law does not explicitly require notification of sex partners or other at-risk contacts of HIV cases. However, in some instances the Local Public Health Administrator or Oregon Health Authority may notify sex partners and other at-risk contacts without the knowledge of, or against the wishes of the source. Oregon law (ORS 433.008) permits the Oregon Health Authority and Local Public Health Administrators to release information obtained during investigation of a reportable disease to a person who may have been exposed to a communicable disease. The law permits the Authority or the Local Public Health Administrator to release individually identifiable information if there is clear and convincing evidence that the release of information is necessary to avoid immediate danger to other individuals or to the public. An example of a circumstance where the Local Public Health Administrator might judge that notification against the source patient's wishes would be a circumstance where a sexual contact is pregnant or known to be HIV-negative. In such circumstances a plan for notification should be established with the Local Health Officer or HST Epidemiologist. Before proceeding LPHA should assure that the case has received counseling about HIV infection,

that confirmatory testing has been done, that the case has received appropriate referrals for medical evaluation and follow-up, and that all reasonable efforts to convince the patient to notify partner(s) him(her)self have failed.

D. Case is a Health Care Worker

Health care providers who routinely participate in procedures that pose a significant risk of bleeding into a patient are encouraged to voluntarily find out if they are HIV-infected. Infected health care workers are encouraged to ask their employer, the LPHA or HST to review their professional practices, to minimize risk of transmission, or to refrain from participating in such procedures.

E. HIV Co-Infected Gonorrhea or Syphilis Case

People with cases of gonorrhea and/or syphilis should be asked about HIV status and tested for HIV. If a person with established HIV infection develops a new case of gonorrhea or syphilis LPHA should offer partner notification and referral regardless of whether or not this was offered at the time of the HIV case report. Notification of potential exposure to gonorrhea and/or syphilis should be accompanied by notification of exposure to HIV and testing offered for HIV in addition to gonorrhea and syphilis and treatment of bacterial sexually transmitted infections.