

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 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 10 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. Presently, effective antiretroviral treatment reduces viral replication through inhibition at various points in the viral life cycle. (Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents – A Working Group of the Office of AIDS Research Advisory Council. October 10, 2006. Available at

<http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. & Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. October 26, 2006. Available at <http://aidsinfo.nih.gov/ContentFiles/PediatricGuidelines.pdf>.)

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. (Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States. Perinatal HIV Guidelines Working Group. October 12, 2006. Available at <http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf>.)

Additional medications can prevent opportunistic infections (OIs) such as disseminated *Mycobacterium avium* complex and *Pneumocystis* pneumonia in the presence of advanced immune deficiency. (Guidelines for the Prevention of Opportunistic Infections Among HIV-Infected Persons - 2002. Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America. June 2002. Available at <http://aidsinfo.nih.gov/ContentFiles/OIpreventionGL.pdf>.) Antiretroviral drugs in current use include nucleoside and non-nucleoside reverse transcriptase inhibitors, protease inhibitors, and fusion inhibitors. Other categories of ART drugs are being tested. 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)

3. CASE DEFINITIONS, DIAGNOSIS, AND LABORATORY SERVICES

In Oregon, both newly diagnosed cases of HIV infection, regardless of severity, and the onset of AIDS 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. Definition of HIV Infection

(Persons aged ≥18 months)

Confirmed Case

A positive result on a screening test for HIV antibody (e.g., repeatedly reactive enzyme immunoassay [EIA]), followed by a positive result on a confirmatory (sensitive and more specific) test for HIV antibody (e.g., Western blot [WB] or immunofluorescence antibody [IFA] test);

OR

A positive result or report of a detectable quantity on any of the following: HIV virologic (non-antibody) tests: HIV nucleic acid (DNA or RNA) detection (a.k.a. "viral load"); HIV p24 antigen test, including neutralization assay; HIV isolation (viral culture).

OR

Diagnosis of HIV infection, based on the laboratory criteria above, that is documented in a medical record by a physician

Suspect Case

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.

(Persons aged <18 months)

Confirmed Case

Positive results on two separate specimens (excluding cord blood) using 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, in a child aged ≥ 1 month; HIV isolation (viral culture);

Presumptive Case

Positive results on only one specimen (excluding cord blood) using the above HIV virologic tests and no subsequent negative HIV virologic or negative HIV antibody tests.

Suspect Case

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.

B. Definition of AIDS

(All ages.)

Confirmed HIV infection (above);

AND at least one from following list:

- Less than 200 CD4+ T-lymphocytes/ μm^3 , or a CD4+ T-lymphocyte percentage of total lymphocytes of less than 14%;
- Candidiasis of esophagus, bronchi, trachea, or lungs;
- Cervical cancer, invasive in persons aged ≥ 13 years;
- Coccidioidomycosis, 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, Burkitt'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 carinii pneumonia;
- Pneumonia, recurrent;
- 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.)

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

OSPHL tests serum and oral specimens for HIV antibodies by EIA; repeatedly reactive samples are tested by WB. OSPHL does not offer rapid antibody testing, HIV RNA detection (a.k.a. “viral load”), HIV p24 antigen test, HIV isolation (viral culture), or testing for resistance to antiretroviral drugs. Rapid testing can be obtained from some LPHA’s and private health care providers. The other tests can be obtained from various private clinical labs. HIV antibody testing at OSPHL is available to LPHA clients, and to others by special arrangement with OSPHL and the HIV Prevention Program.

Except in the case where the sample is collected from a pregnant woman, laboratories are not permitted to test specimens for HIV in Oregon unless the patient has given informed consent for testing. If the testing is conducted under the auspices of a licensed health care provider, such consent may or may not be in written form. When testing is conducted in counseling and testing sites funded through the Oregon State Public Health Division or by an independent entity that submits specimens to OSPHL for testing, a triplicate form attesting to the fact that informed consent was obtained and providing demographic information about the patient should be signed by the provider or designee. The original should be retained by the collection site, and the pink and gold copies submitted to the laboratory with the specimen. Use Form OHD 44 for specimens submitted to OSPHL (Appendix 1 consists of an example of OHD 44.). (For testing done at clinical laboratories other than OSPHL, laboratories are no longer required to collect verification of informed consent prior to conducting the test or to submit this information to Oregon State Health Division.) Copies of OHD 44 are available from the HIV Prevention Program (971-673-0153). Additional information about informed consent for HIV testing and laboratory requirements for HIV test reporting can be found on the HST website at <http://oregon.gov/DHS/ph/hiv/data/index.shtml>.

For HIV antibody testing, 5-7 ml of blood in a 13x100 Vacutainer® tube is required. Contact the virology section at OSPHL (503-229-5882) or the state HIV Program (971-673-0181) with questions about HIV testing.

D. Other Laboratory Methods (Not Available at OSPHL)

HIV RNA detection (a.k.a. “viral load”), HIV p24 antigen test, HIV isolation (viral culture), and testing for resistance to antiretroviral drugs are not available at OSPHL. Rapid testing can be obtained through a number of LPHAs, and private laboratories and health care providers. The others tests can be obtained from various private clinical labs. HIV antibody testing at OSPHL is available to LPHA clients and to others by special arrangement with OSPHL and the HIV Prevention Program.

4. ROUTINE CASE INVESTIGATION

A. Background

After the advent of mandatory HIV (not AIDS) reporting in Oregon in 2001, most laboratory and physician reports of HIV infection and AIDS were made directly to HST, and state HST staff conducted case investigations by interviewing the medical provider or abstracting information from the medical

record. Case investigation by Oregon State Public Health – unique to HIV/AIDS among reportable diseases – was intended to prevent inadvertent disclosure of confidential HIV-related health information through establishment of a single, secure site to collect and store case report data. Until April 2006, names of reported HIV (not AIDS) case-patients were converted by HST to a unique identifier code after a ≤ 90 day retention period to facilitate collection of the case report. In contrast, the names of persons with reported cases of HIV infection that have progressed to AIDS have been permanently retained in the public health registry since the commencement of AIDS reporting in 1983. In April 2006, Oregon abolished its system of converting names of HIV (not AIDS) case-patients to unique codes. Since then, all cases of HIV infection regardless of severity are recorded by name in the state's HIV/AIDS registry. Beginning in November 2007, new HIV/AIDS cases should be directly reported to LPHA's, and LPHA's will assume responsibility for completing case reports for newly reported HIV cases.

B. 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 (both EIA and WB test positive) HIV antibody test 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 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 §1C2). Either because of concerns about maintenance of case-patient confidentiality or for lack of staff trained in interviewing sexually transmitted disease patients, some LPHA's may elect to assign responsibility for primary case investigation to HST by mutual agreement.

a. Confirmed Case (See §3B)

- i. Verify that the case has not been previously reported. Or, if the report indicates that the case has progressed from HIV (not AIDS) to AIDS (i.e. CD= T-lymphocyte count <200 or $<14\%$, or presence of AIDS-defining condition) (See §2B.), verify that the progression to AIDS has not previously been reported. HST staff (971-673-0183) can assist by comparing the new report to cases already recorded in the statewide registry. If the case has previously been reported *and* this is not the first report of progression from HIV (not AIDS) to AIDS, no additional investigation is required.
- ii. **Completing the Case Report Form** (*If case not previously reported or this is first report of progression of reported HIV (not AIDS) case to AIDS*). Collect all available information needed to complete an adolescent/adult HIV/AIDS case report form (Cases aged ≥ 13 years; see Appendix 2.) or the pediatric HIV/AIDS case report form (Cases aged <13 years; see Appendix 3.) from the facility/s or health care provider/s where the diagnosis was made and any medical treatment rendered. A supplemental case report form should be completed for each new facility or provider from which data are obtained. 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. Appendix 4 (*Technical Guidance for HIV/AIDS Surveillance Programs – Volume II: Data Collection Resources and Reporting*) contains specific instructions for completion of the case report forms.

iii. Contacting the Patient to Verify Case Report Details and Offer Referral for Services

1. Advise the physician or other regular health care provider that someone from public health will contact the patient (or parent or guardian if the patient is aged <13 years) to 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. Most LPHA's do not have available staff who are trained to conduct partner counseling and referral services and have time dedicated to this function. If you work in one of these LPHA's, after completing the initial case report with the medical provider, you should forward it to the HST Surveillance office via secure fax (971-673-0179). A Disease Intervention Specialist (DIS) from the Health Division will contact the patient to verify the personal and demographic information collected from the provider and initiate partner counseling and referral services. In some cases, the physician or regular health care provider may indicate that he/she would like to advise the patient of the impending contact by the LPHA. In such cases, please note this request in the comments section of the case report to notify the DIS to check with the provider before attempting to contact the patient. Rarely, a medical provider may believe that 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 (071-673-0181)
 3. A few LPHA's have agreed to make public health staff who are trained to conduct partner services and referral interviews available for this purpose. If you work in one of these LPHA's, after completing the initial case report with the medical provider, you should then forward it to the person or persons responsible for partner counseling and referral in your LPHA. That person will interview the patient to verify personal and demographic information on the case report and initiate partner counseling and referral services. If the physician or regular health care provider has indicated that he/she would like to advise the patient of the impending contact by the LPHA, the provider should be given a reasonable opportunity to make this contact before the LPHA attempts to contact the patient.
 4. Upon contact by the LPHA or the DIS from the State Health Division, review the case report with the patient and initiate partner counseling and referral services. If the patient provides information that augments or contradicts information on the case report collected from health care provider/s, complete a supplemental case report form including only the new or contradictory information. (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.) This contact should be made by a disease intervention specialist or other LPHA staff trained in techniques for interviewing sexually transmitted disease patients.
- iv. Send the completed case report form by to HST HIV Data and Analysis Program by any of the following methods (Case report forms and other documents containing identifiable protected health information must not be faxed to non-secure locations or sent by electronic mail.):
- US mail or interoffice mail: (Mark "Confidential.") Send to HST Section, Office of Disease Prevention and Epidemiology, 800 NE Oregon St., Suite 1105, Portland, Oregon 97232, Attention: HIV Surveillance Program.
- Secure fax. 971-673-0179.
- Electronic submission via secure file transfer protocol or other secure transmission methods: contact the HIV Data and Analysis Program at 971-673-0183.
- b. Suspected 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 §3B), the case may be called confirmed and should be investigated as in §4B1. If laboratory confirmation of infection cannot be verified, no additional investigation is necessary.

5. CONTROLLING FURTHER SPREAD

A. Patient/Household Education

- a) If the patient is not receiving HIV related medical services, refer the patient to a local medical resource. Some resources:
 - i. Statewide
 - HIV/STD/TB Program, HIV Care Services Section (971-673-0144)
 - Research & Education Group (503-229-8428 or 1-800-875-8428) may be helpful if client is unable to access services quickly or if unsure about seeking care. One-on-one HIV education with an RN – may include initial viral load and T-cell testing. Access to community based HIV research.
 - ii. Portland Metro Area, (Clackamas, Columbia, Multnomah, Washington, and Yamhill counties in Oregon, and Clark County in Washington)
 - HIV Intake Services (503-517-3590)
- b) If the patient desires substance abuse treatment services, refer him/her to local substance abuse treatment resources, including:
 - Oregon Alcohol & Drug Helpline (1-800-923-4357)
 - Oregon AIDS Hotline (1-800-777-2437 or www.oregonaidshotline.com)
 - HST, HIV Care Services Program (971-673-0144).
- c) If the patient desires social services refer him/her to:
 - i. Statewide
 - HST, HIV Care Services Program (971-673-0144)
 - Local HIV Case Management
 - ii. Portland Metro Area
 - HIV Intake Services (503-517-3590)
- d) Offer assistance with partner counseling and referral services (PCRS) (a.k.a., “partner notification”). If the patient desires PCRS, 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.
- iii. 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.

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. 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.
2. 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.
3. 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.
4. 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 bleach solution or tuberculocidal germicides.

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.

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 Naive Sex Partners or other Contacts

Oregon law (OAR 333-012-0270) permits physicians to "notify an individual who has had a substantial exposure to another individual whether that individual has been HIV tested, and, if so, what the test results were, provided that: (a) The individual whose HIV test information released is notified in writing of this disclosure; and (b) The identity of the HIV tested person is not explicitly disclosed during the notification process."

Before proceeding with any attempts to notify naïve partners, LPHA staff should assure that the case has received counseling about HIV infection and that confirmatory testing has been done. Assure that the case has received appropriate referrals for medical evaluation and follow-up. Seek assistance from a Disease Intervention Specialist or HST before attempting to notify a naïve partner. Before considering notification of a naïve partner against the patient's wishes, work with the case-patient and encourage them to notify partner(s) themselves.

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.